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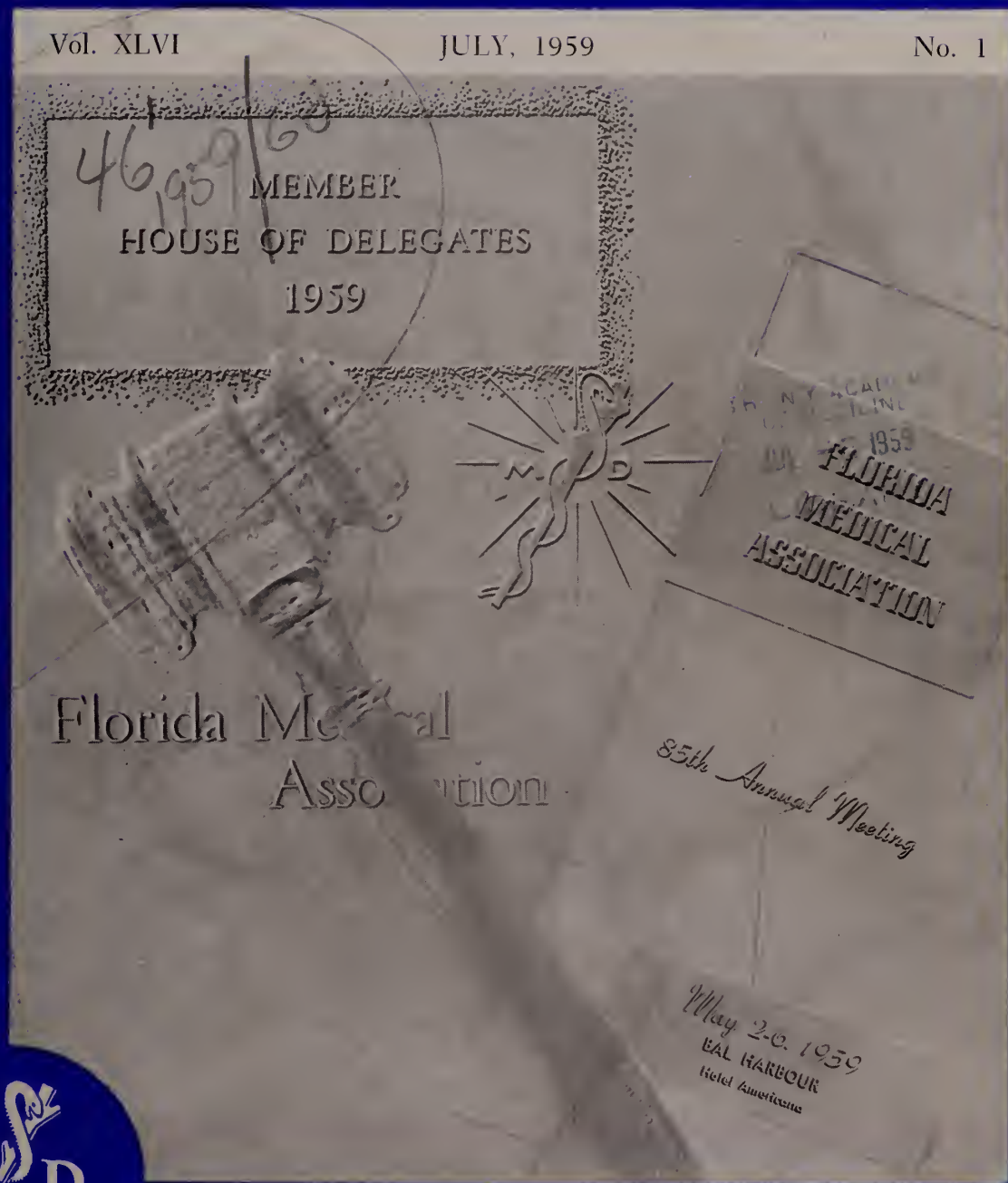
# The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLVI

JULY, 1959

No. 1



Florida Medical  
Association

85th Annual Meeting

May 20, 1959  
EAL HARBOR  
Hotel Americana

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OFFICIAL PUBLICATION OF THE  
FLORIDA MEDICAL ASSOCIATION



## wherever STAPHYLOCOCCI PRESENT A PROBLEM CHLOROMYCETIN

Increased incidence of staphylococcal infections has been reported for Europe, Britain, Australia, New Zealand, and the Americas.<sup>1-5</sup> World-wide reports indicate that many of the organisms responsible for these infections are resistant to commonly used antibiotics.<sup>1-3,5-14</sup> However, this ubiquitous pathogen, according to studies from Germany,<sup>8</sup> Canada,<sup>9</sup> Uganda,<sup>10</sup> New Zealand,<sup>11</sup> England,<sup>12</sup> and the United States,<sup>13,14</sup> remains sensitive to CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including capsules of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, with certain other drugs, adequate blood studies should be made when the patient requires prolonged intermittent therapy.

**REFERENCES:** (1) Smith, I. M.: *Staphylococcal Infections*, Chicago, Year Book Publishers, Inc., 1958, p. 21. (2) Pryles, C. V.: *Lancet* 2:1609, 1958. (3) Monro, J. A., & Markham, N. P.: *Lancet* 2:186, 1958. (4) Purser, B. N.: *M. J. Australia* 2:441, 1958. (5) R. E. O., in National Conference on Hospital-Acquired Staphylococcal Disease, Sept. 15-17, 1958, Atlanta, Georgia, U. S. Health, Education, and Welfare, Communicable Disease Center, 1958, p. 11. (6) Rountree, P. M., & Beard, M. A.: *M. J. Australia* 2:441, 1958. (7) Mudd, S.: *J.A.M.A.* 166:1177, 1958. (8) Fischer, H. G.: *Deutsche med. Wochenschr.* 84:257, 1959. (9) Royer, A., in *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 783. (10) Hennessey, R. M., & Miles, R. A.: *Brit. M. J.* 2:893, 1958. (11) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (12) Oswald Shooter, R. A., & Curwen, M. P.: *Brit. M. J.* 2:1305, 1958. (13) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9:30, 1958. (14) Borchardt, K. A.: *Antibiotics & Chemother.* 8:564, 1958.

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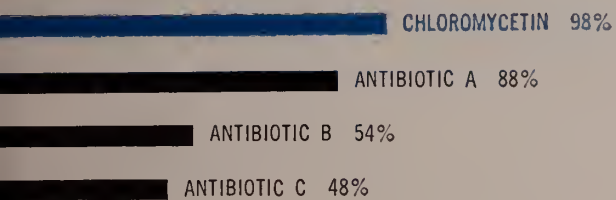
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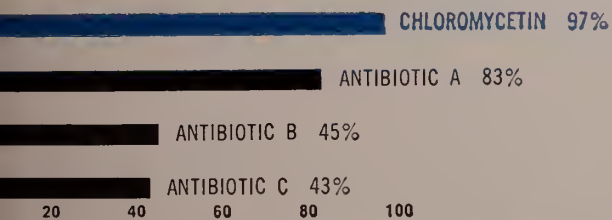


ANTIBACTERIAL SENSITIVITY OF STAPHYLOCOCCI, FROM TWO SOURCES, TO CHLOROMYCETIN AND TO THREE OTHER ANTIBIOTICS\*

HOSPITAL PATIENTS (201 strains)



UNIVERSITY CLINIC PATIENTS (209 strains)



\* Adapted from Fischer.<sup>8</sup>

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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VOLUME XLVI, No. 1

• July, 1959

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This Journal is not responsible for the opinions and statements of its contributors.

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**DECADRON**—the new and most potent of all corticosteroids, eliminated fluid retention in all but 0.3 percent of 1500 patients†, and induced beneficial diuresis in nearly all cases of pre-existing edema.



# **Decadron**\*

DEXAMETHASONE

**treats more patients  
more effectively**

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†Analysis of clinical reports.

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sound

*ethically promoted*

# Meta Cine

*vaginal douche powder*

Meta Cine represents a carefully designed formula which provides the physician with a vaginal douche preparation which safely and effectively maintains a clean healthy vagina.

Meta Cine is a combination of several ingredients clinically established as valuable in promoting proper vaginal hygiene. Diluted for use, Meta Cine possesses the desired pH (3.5); contains the mucus digestant, papain, which dissolves mucus plugs and coagulum; contains lactose to promote growth of desirable döderlein bacilli, and methyl salicylate for soothing stimulation of circulation within the vaginal walls.

Its pleasant, deodorizing fragrance also meets the esthetic demands of your patients.

Meta Cine is promoted exclusively to the medical profession, and recommends itself as your preparation of choice for patients who might otherwise indulge in unsupervised self-medication with potentially damaging nonphysiologic douches.

Supplied in 8-oz. containers, and boxes of 30 individual-dose packettes. Two teaspoonfuls, or contents of one packette, in 2 quarts of warm water, douche as prescribed.

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In recognition of the responsibility of the pharmaceutical industry to aid postgraduate medical education, Lederle originated its Symposium Program eight years ago. Initiated with a meeting sponsored by the Knoxville Academy of Medicine and continued with other medical organizations, the program presents up-to-date information of clinical significance to physicians throughout the United States and Canada. Through Symposia, over 50,000 physicians have had the opportunity to hear and question specialists in every field and, with their wives, participate in the activities of a Symposium day.

You and your wife may wish to attend one of the Symposia below.

**JEKYLL ISLAND, GEORGIA**—Thursday, August 27, 1959  
The Jekyll Club

**BATON ROUGE, LOUISIANA**—Friday, Sept. 18, 1959  
The Capitol House Hotel

**BEAUMONT, TEXAS**—Saturday, September 19, 1959  
The Hotel Beaumont

**KANSAS CITY, KANSAS**—Friday, September 25, 1959  
Battenfeld Memorial Auditorium

**INDIANAPOLIS, INDIANA**—Wednesday, Sept. 30, 1959  
The Sheraton-Lincoln Hotel

**OKLAHOMA CITY, OKLAHOMA**—Friday, October 2, 1959  
The Skirvin Hotel

**BIRMINGHAM, ALABAMA**—Sunday, October 11, 1959  
The Dinkler-Tutwiler Hotel

**TACOMA, WASHINGTON**—Wednesday, October 14, 1959  
The Hotel Winthrop

**TRAVERSE CITY, MICHIGAN**—Friday, October 23, 1959  
The Park Place Hotel

**LUBBOCK, TEXAS**—Saturday, October 31, 1959  
The Lubbock Country Club

**ST. CHARLES, ILLINOIS**—Wednesday, November 4, 1959  
The St. Charles Country Club

**DALLAS, TEXAS**—Friday, November 6, 1959  
The Hilton Hotel

**WICHITA, KANSAS**—Saturday, November 7, 1959  
The Hotel Broadview

**SCHENECTADY, NEW YORK**—Thursday, November 12, 1959  
The Mohawk Golf Club

**CORPUS CHRISTI, TEXAS**—Friday, November 13, 1959  
The Robert Driscoll Hotel

**RIVERSIDE, CALIFORNIA**—Sunday, November 15, 1959  
The Mission Inn

**SANTA BARBARA, CALIFORNIA**—Wednesday, Nov. 18, 1959  
The Santa Barbara Biltmore

**MOLINE, ILLINOIS**—Wednesday, December 2, 1959  
The LeClaire Hotel

*Announce*

*Announce*

A  
Symposium  
Clinical I

A  
Symposium on  
Practical Procedures  
and  
Modern Concepts of Therapy

THURSDAY

WEDNESDAY, APRIL 15, 1959

THE HOTEL ST. GEORGE  
Brooklyn, New York

A  
Graduate Seminar  
with  
able Discussions

FEBRUARY 21, 1959

THE WESTWARD HOTEL  
Anchorage, Alaska

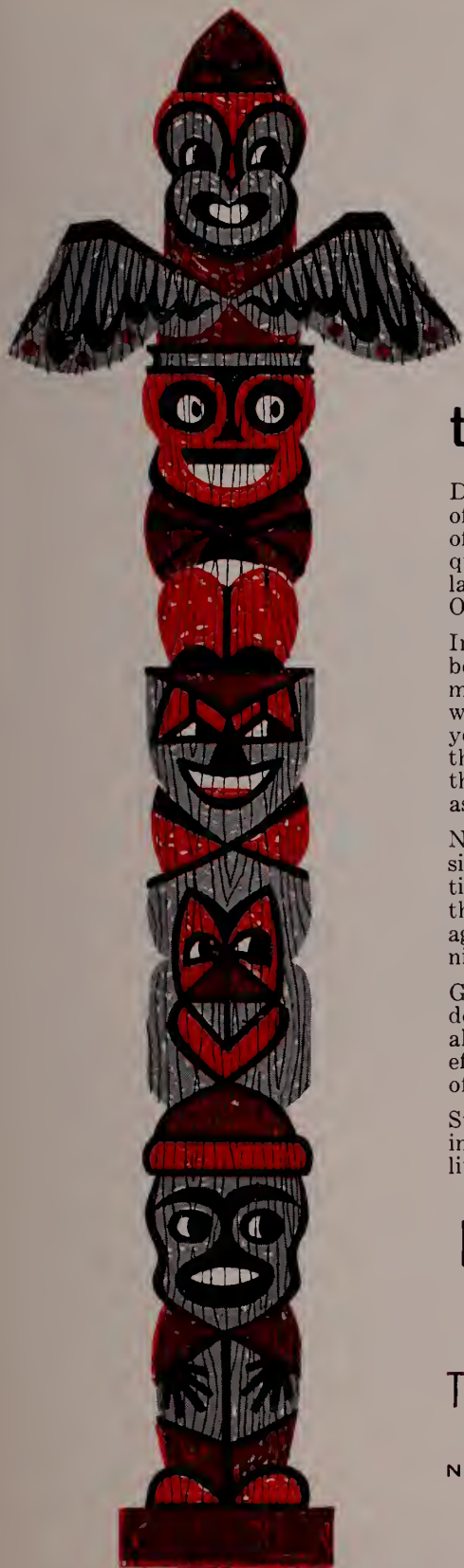


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“It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose.”<sup>1</sup>

<sup>1</sup>Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, *Postgraduate Medicine*; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.



## the **disease** of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is “one of the most widespread and serious protozoan diseases of man,” yet “there is no parasite more often misdiagnosed than is *E. histolytica*.” Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

## new **Glarubin**

TABLETS

*specific for intestinal amebiasis*

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Combines the anti-inflammatory effect of hydrocortisone with the comprehensive bactericidal action of the antibiotics.

OINTMENT: Tubes of  $\frac{1}{8}$  oz. and  $\frac{1}{2}$  oz. (with applicator tip) for ophthalmic or dermatologic application.

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Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

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OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { LOTION: Plastic squeeze bottles of 20 cc.

POWDER: Shaker-top bottles of 10 Gm.

**'POLYSPORIN'**®

brand ANTIBIOTIC OINTMENT

Offers combined antibiotic action for treating conditions due to susceptible organisms amenable to local medication.

OINTMENT: Tubes of  $\frac{1}{2}$  oz., 1 oz. and  $\frac{1}{8}$  oz. (ophthalmic tip).



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



New

**FORMULA:**

Each 15 cc. (tablespoon) contains:  
 Sulfaguanidine ..... 2 Gm.  
 Pectin ..... 225 mg.  
 Kaolin ..... 3 Gm.  
 Opium tincture ..... 0.08 cc.  
 (equivalent to 2 cc. paregoric)

**SUPPLIED:**

Bottles of 16 fl. oz.  
 Exempt Narcotic.  
 Available on Prescription Only.

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**POMALIN**  
 Liquid

TRADE MARK

**RASPBERRY FLAVOR**

and pink color make POMALIN pleasant to  
 take and appealing to both children and adults.

- ✓ Curbs excessive peristalsis
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- ✓ Soothes inflamed mucosa
- ✓ Provides intestinal antiseptics

**DOSAGE:**

**ADULTS:** Initially 1 or 2 tablespoons from  
 four to six times daily, or 1 or 2 teaspoons  
 after each loose bowel movement;  
 reduce dosage as diarrhea subsides.

**CHILDREN:**  $\frac{1}{2}$  teaspoon (=2.5 cc.) per  
 15 lb. of body weight every four hours day  
 and night until stools are reduced to five  
 daily, then every eight hours for three days.



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CAPSULES

ANTICHOLINERGIC • ANTISECRETORY • ANTI-ENZYME • ANTACID

*with a medical splint*

Aluscop capsules, a unique preparation equally as effective as the liquid form, provide rapid and prolonged relief of pain, discomfort and dysfunction in the management of peptic ulcer, hyperacidity, gastro-intestinal spasm or hyperirritability.

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- **Methscopolamine nitrate**—the most potent antisecretory agent—35 times that of atropine sulfate, inhibits gastric acid secretion and acts as a "medical splint" through its visceral antispasmodic action.
- **Dihydroxy aluminum aminoacetate and magnesium hydroxide**—two of the most effective antacids—exert dual action without constipating effect.
- **Sodium lauryl sulfate**—a pepsin inactivator—minimizes pepsin erosion and further destruction of tissue to hasten healing of lesions.

**Composition:** 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

**Dosage:** 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

**Supplied:** Bottles of 100 capsules and 12 oz. of suspension.



Lloyd, Dabney & Westerfield, Inc.

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*Fine Pharmaceuticals Since 1894*

**A NEW USE  
FOR VESPRIN**

**FROM:  
ANXIETY  
AND TENSION  
TO: EMOTIONAL  
STABILITY**

**VESPRIN**  
SQUIBB TRIFLUPROMAZINE HYDROCHLORIDE

made the difference  
in anxiety and tension states / psychomotor agitation /  
phobic reactions / obsessive reactions / senile agitation  
/ agitated depression / emotional stress associated with a  
wide variety of physical conditions

In the patient with anxiety and tension symptoms — Vesprin calms him down without slowing him up...and does not interfere with his working capacity. Vesprin permits tranquilization *without* oversedation, lethargy, apathy or loss of mental clarity.<sup>4</sup>

And Vesprin exhibits an improved therapeutic ratio — enhanced efficacy with a low incidence of side effects; no reported hypotension, extrapyramidal symptoms, blood dyscrasia or jaundice in patients treated for anxiety and tension.<sup>1,2,3</sup>

**dosage:** for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy 3:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. 24:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes 2:3, 1959. 4. Kris, E.: Clinical Research Notes 2:1, 1959. <sup>1</sup>VESPRIN® is a Squibb Trademark

**Vesprin — the tranquilizer that fills a need in every major area of medical practice**

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Squibb Quality —  
the Priceless Ingredient





extends the range of relief in HAY FEVER

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al medications  
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↑  
NEW

**isoclor**

acts here

to relieve both nasal  
.....

and chest discomfort  
↓

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provides both . . . / upper respiratory decongestion  
and bronchial decongestion

Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

**COMBINES** the nasal and bronchial decongestant action of d-isoeephedrine with the histamine blocking action of chlorpheniramine.

**RELIEVES** the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—let s the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

TABLETS AND SYRUP for adults and children . . .

COMPOSITION:

	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate	4 mg.	2 mg.
d-Isoeephedrine HCl	25 mg.	12.5 mg.

DOSE: Tablets: One tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d.; Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

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*superior* antiallergic efficacy  
with new *low dosage*

**NEW**  
**Aris**

- combines the anti-inflammatory, antiallergic and antihistaminic effects of two agents—ARISTOCORT and chlorpheniramine which, separately, have been proved highly effective in the treatment of allergy
- permits greater latitude in adjusting dosage to minimum level needed for maintenance, because ARISTOCORT and chlorpheniramine are supplied in the lowest dose tablets available for each component alone
- supplies ascorbic acid for increased demand in stress conditions

**Indications:** Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.

**Dosage:** One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.

**Precautions:** Drowsiness may occur, and is usually due to the antihistaminic effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with ARISTOMIN have been relatively infrequent and minor in nature. However, since ARISTOCORT Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to cortico-

steroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.

Further information available on request.

**Supply:** Each ARISTOMIN Capsule contains:

ARISTOCORT® Triamcinolone . . . . . 1 mg.  
Chlorpheniramine Maleate . . . . . 2 mg.  
Ascorbic Acid . . . . . 75 mg.

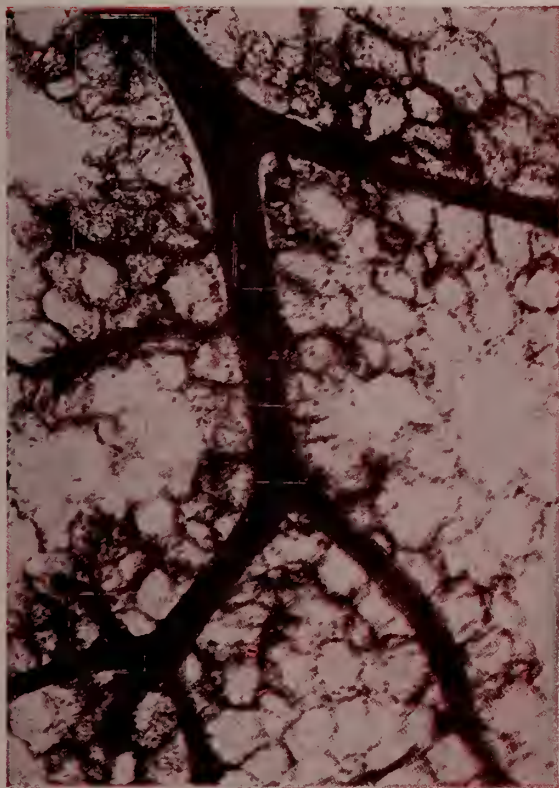
Bottles of 30 and 100

**References:** 1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.

## CORT IN ANTIHISTAMINE COMBINATION

**min<sup>®</sup>**

Steroid-Antihistamine Compound LEDERLE



(lung x 65, injected with carbon-gelatin)

### *comments by clinical investigators:*

*"I would conclude that ARISTOMIN is truly a worthwhile aid in treating allergic problems."<sup>1</sup>*

*"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."<sup>2</sup>*

*"In general . . . it [ARISTOMIN] is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."<sup>3</sup>*

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# What's Your Corticosteroid Score?

		True	False
1	Corticosteroids relieve rheumatic pain by raising the pain threshold.	<input type="checkbox"/>	<input type="checkbox"/>
2	Corticosterone is the only corticosteroid identified in adrenal venous blood.	<input type="checkbox"/>	<input type="checkbox"/>
3	Approximately 10 mg. of urinary 17-ketosteroids are excreted daily during normal adrenocortical function.	<input type="checkbox"/>	<input type="checkbox"/>
4	The pioneer experiments on the effects of adrenalectomy were performed by Addison.	<input type="checkbox"/>	<input type="checkbox"/>

*For answers to quiz, see opposite page.*



scores  
highest  
in clinically  
important  
tests

**METICORTEN®**  
prednisone

Even in long-term therapy, diet and salt  
restrictions are usually unnecessary  
—a benefit of METICORTEN repeatedly  
noted by investigators.

METICORTEN—1, 2.5 and 5 mg. tablets.

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corticosteroid quiz

**ANSWERS:** 1. False—by altering tissue reaction. 2. False—only hydrocortisone has been so identified. 3. True. 4. False—performed by Brown-Séquard.



## CO-PYRONIL<sup>TM</sup> provides quick relief that lasts and lasts

Just two or three Pulvules® Co-Pyronil daily will usually keep your hay-fever patients symptom-free and on the job all day long. Not *just* an antihistamine, Co-Pyronil is a triple combination that assures more complete relief from hay fever and other allergies.

Each Pulvule contains:

**a vasoconstrictor**, Clopane® Hydrochloride (12.5 mg.), to complement the action of two antihistamines by opening swollen nasal passages.

**a fast-acting antihistamine**, Histadyl<sup>TM</sup> (25 mg.), to provide relief usually within fifteen to thirty minutes.

**a long-acting antihistamine**, Pyronil® (15 mg.), to maintain relief for eight to twelve hours.

Also supplied as suspension and pediatric Pulvules.

Co-Pyronil<sup>TM</sup> (pyrrobutamine compound, Lilly) Histadyl<sup>TM</sup> (thenylpyramine, Lilly)

Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly) Pyronil® (pyrrobutamine, Lilly)

## Presidential Address

JERE W. ANNIS, M.D.

LAKELAND

You have available in the Handbook for your perusal, the report of the Board of Governors—the factual record of its actions and transactions during the past year. I shall not belabor these points, with which most of you are as intimately acquainted as I, but shall, instead, utilize these few minutes—traditionally allotted to your retiring Executive—to summarize for you my impressions of the role and the responsibility of organized Medicine in these turbulent times.

Our entire social order, it seems to me, is engaged in a tremendous evolutionary struggle to determine whether or not this Democracy of ours can endure and survive the onslaughts of its own proponents—to determine whether this or any ideology can preserve inviolate those cherished and hallowed principles of freedom, opportunity and individual responsibility that burned so fiercely in the breasts of the founders of our country—to determine whether such a Democracy can continue with dignity the orderly direction and administration of its affairs—or whether it must succumb to the poorly conceived, irrational, often vicious actions and hallucinations of those who, living under its protecting guardianship, would attempt, by sedition, to destroy it from within. These, indeed, are crucial times in which we find ourselves participating in the testing of a great principle—a great faith.

Where, in this struggle, does Medicine's responsibility lie?

As physicians, we have a twofold obligation. We have, first of all, the duty and responsibility to exercise our rights as citizens, and especially as leaders in our community—as individuals whose advice the public is inclined, traditionally, to seek and to respect. In this capacity we are concerned with the picture of our entire social order—with all the facets—social—political and



Dr. Annis

economic—of our government and our civilization. And if we would exert our influence here, wisely and effectively, we must act in a scholarly, deliberate manner, voicing rational conclusions based upon a careful study of history; since, indeed, the past is our only reference work for the future. Certainly the lasting and inspirational opinions, beliefs and ideals that our titanic ancestors wrung from the souls and bodies of early Americans in founding this great land should be a basic and extremely familiar part of the equipment with which we approach today's problems.

Certainly the frugality—the self discipline—and the self reliance that formed the foundation for the launching platform from which this Democracy of ours hurtled skyward 183 years ago are tending to disappear rapidly from the national scene. They are being replaced by a kind of decadent emotional and physical overindulgence arising from a profligate and wanton dissipation of moral and spiritual wealth, and leading to



cringing dependency on and subservience to the paternalistic big brother genie which has risen from the ashes of our free will and independence. This thriving parasite threatens, through its leech-like activity, to bleed white and lifeless the greatest Democracy—the greatest working expression of man's finest hopes and dreams—that the world has ever known.

It is into this huge, revolting jelly-like mass of socialism that we must drive the explosive fist of energy, enterprise and courage to destroy this horror while life and health still remain in our cherished Democracy. One of the great ends of this Democracy is to raise—by popular effort—the average level of our moral, spiritual and material possessions. But let us never become a Nation of average people. Let us never suppress nor deny the right of opportunity—of success—or the rewards of enterprise and vision. Let us remain always a Nation of individuals following a glowing set of ideals—never a Nation of unimaginative, unthinking serfs. Let us recall Theodore Roosevelt's words: "Division of power in government is merely the division among the representatives of the powers delegated to them. The term must not be held to mean that the people have divided their power with their delegates. The power is the *people's*—and *only* the people's."

Certainly, as this Country again approaches a crisis in its existence, leadership, direction and guidance from the Almighty will once more appear, as in the past, to the end that our efforts may be directed into the proper channels—and this cherished Democracy of ours saved from destruction. Let us be sure that we—the men of Medicine—do our share in forwarding this cause.

The second obligation of the Medical Profession is the responsibility of developing within our own discipline an honest, orderly and efficient operation which may serve as an example to all Americans, and which may take its place as one part of the kaleidoscopic picture of our society. To accomplish this will not be easy; and unfortunately, we have become accustomed to the indolence and irresponsibility that beset children of overindulgent parents. For this reason, it will be difficult initially to muster the determination—the hard work—the persistence and actual deprivation that will be needed for the job. It will require much intellectual effort, much devotion and dedication, and much self discipline to bring our house in order, that it may assume with pride, honor and harmony, its proper place in today's civilization.

We must face honestly the problems that are before us—and we must face them in a realistic and scientific manner. We must accept, for instance, the very obvious fact that the people of this country wish, by and large, some provision whereby they can anticipate and prepay their medical expenses. This is a logical and entirely reasonable desire, based primarily upon the necessity of eliminating this high priority item from the rest of their daily budget. This does not mean that management—government—or any third party—must necessarily assume the cost of such medical care. It is simply an expression of a desire to anticipate and prorate it. We must study such national desires and philosophies in a careful, cooperative and constructive manner. And we must help to channel such basic thinking into practical methods of performance which will, at the same time, conform with the fine ideals and heritage of our profession. This can be done—this *must* be done—and Medicine itself must lead the way. We must, to an extent, leave our hill-tops and walk, like the physicians of old, in the valley of the less fortunate, in order that the knowledge—the sympathy—and the understanding gained there may help us to fashion, with them, the means of their betterment. Some of the sincerity and much of the vigor necessary to do this have escaped us in these inflationary times. Let us recapture them before it is too late.

And so, in this overprivileged era of opulence and abundance of material things, both from a professional and from a national standpoint, it behooves us to turn our eyes, not toward Rome, but toward Sparta—for those traits and virtues so necessary to protect our strength—our honor—and our dignity.

And now, at the close of this year's work, I would indeed be remiss if I did not express my sincere and deep appreciation to all of you who have worked so assiduously this year. Especially should I like to commend the Executive Committee, the Board of Governors—and all the Committee Chairmen and members who have put in untold hours, gratuitously, in your behalf. Among those who have sacrificed most are the Medicare Committee headed by Dr. Dobbins. To all the rest of you who have served in special capacities, my thanks. Harold Parham and his ever faithful and diligent staff, in Jacksonville, have reached, this year, a new high in cooperation, effectiveness and unselfish devotion to our interests. They are, indeed, your Florida Medical Association.



One last personal commendation to the physician to whom—more than any other—each of you is personally indebted for his unselfish dedication and service—my friend and your Secretary—Dr. Sam Day. Without all these people, whatever success we have had this past year would have been impossible.

Although I am not conscious, at this time, of any intentional errors that I have made as your

President, I am neither so vain nor so insensible of my defects as not to suppose that, unwittingly, I have erred on many occasions. I can only hope that such mistakes may not result in any grievous consequences to the Association—and pray to the Good Lord for your indulgence and His forgiveness.

I thank you—for everything.  
Box 1021.

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## Board of Governors, Florida Medical Association 1959 - 1960



Members of the Board of Governors for the year 1959-1960 are shown just prior to their first meeting at the Americana Hotel, Bal Harbour, Miami Beach, May 6, 1959. Seated (left to right) are Dr. Samuel M. Day, Jacksonville, Secretary-Treasurer of the Association; Dr. Leo M. Wachtel, Jacksonville, President-Elect; Dr. Ralph W. Jack, Miami, President; Dr. Jere W. Annis, Lakeland, Immediate Past President, and Dr. William C. Roberts, Panama City. Standing (left to right) are Dr. Ralph S. Sappenfield, Miami; Dr. Alpheus T. Kennedy, Pensacola; Dr. John D. Milton, Miami; Dr. H. Phillip Hampton, Tampa, and Dr. Meredith Mallory, Orlando. Not shown are Dr. Reuben B. Chrisman Jr., Coral Gables, and Dr. S. Carnes Harvard, Brooksville.





# Proceedings

## Eighty-Fifth Annual Meeting

*Florida Medical Association*

*Bal Harbour, Miami Beach, May 3-6, 1959*

### General Session

The Eighty-Fifth Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, May 4, in the Grand Ballroom of the Americana Hotel, Bal Harbour, Miami Beach, Florida, by President Jere W. Annis.

Invocation was pronounced by Father Joseph Devaney, Holy Redeemer Church, Miami.

"Almighty and Merciful God, who hast entrusted each of us with a living soul made in Thine image, and furnished that soul with the sacred temple of the human body;

"Bless the deliberations of these guardians of that sacred temple—the members of the Florida Medical Association—that they may rule themselves wisely and well.

"Saving what Thou savest, sparing what Thou would spare, remembering always that it is Thou who restorest what they treat—Thou who healest what they cure.

"Through Christ Our Lord. Amen."

Dr. Annis: "At this time, Dr. Robert P. Keiser, President of the Dade County Medical Association, will address the assembly."

Dr. Keiser: "President Annis, Members of the Florida Medical Association and guests:

"I consider it quite an honor and a pleasure to be here this morning and have the privilege of

welcoming you to Dade County and Miami Beach in behalf of the Dade County Medical Association. We in this area take pride in having you with us again for this eighty-fifth meeting of the Association.

"Each individual member has a right and should be proud of this society. Certainly we are a young state chronologically and medically as compared to some others. But this fact has had its advantages in giving us a greater opportunity for progress and leadership in organized medicine without having to constantly hurdle the barriers of old prejudices, fixed inflexible customs and stodginess so familiar in the older groups.

"In this world today of changing social idealisms and jet propelled advances in scientific knowledge, we in medicine cannot merely keep abreast of the times but must provide constructive leadership for the future, thus insuring the best in health and welfare for the people of this county not only in scientific medicine but in its social ramifications as well. We cannot sit back, drag our heels, and say, 'This ain't the way we used to do it.'

"As we review the past years, this year which is about to close, comparing the work accomplished each year and the steady improvement in our scientific programs, one can have no doubt

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#### Opposite Page

(1) The House of Delegates deliberates on matters presented; (2) Dr. Meredith Mallory of Orlando, and Dr. Burns A. Dobbins Jr. of Fort Lauderdale stand following their election to the House of Delegates of the American Medical Association; (3) Dr. Robert P. Keiser of Coral Gables, president of the Dade County Medical Association, delivers the Address of Welcome; (4) Dr. Irvine H. Page of Cleveland, guest of President Annis, presents the feature address; (5) and (6) At the President's Reception are (left to right) Mrs. Jere W. Annis, Dr. Annis; Mrs. Ralph W. Jack and Dr. Jack; (6a) Dr. Louis M. Orr; (7) Dr. Lawrence E. Geeslin of Jacksonville presides at the General Scientific Session; (8) Dr. Jack is escorted to the platform for his inauguration as President by Dr. Ralph S. Sappenfield of Miami and Dr. S. Carnes Harvard of Brooksville; (9) The official gavel is presented to Dr. Jack by Dr. Annis, and (10) Dr. Jack affixes the Past President's pin in Dr. Annis' lapel. (11) Dr. Leo M. Watchel of Jacksonville accepts the nomination as President-Elect. (12) One of Dr. Jack's first official duties was the presentation of the Association's Certificate of Merit to Dr. Edward Jelks of Jacksonville.

that this state Association has attained a maturity, provided leadership and accomplished an excellence of purpose second to none.

"On the lighter side, I'm sure that by now most of you have partaken of at least some of our local resources available for your pleasure and your play. By all means do not neglect or deprive yourselves of this all important facet of the meeting.

"Again, let me say we are honored to have you with us, extend our wishes for a most successful meeting and a most cordial welcome this year and for many years to come."

President Annis recognized Dr. William R. Carter, President-Elect, Medical Association of the State of Alabama.

Dr. Annis: "Ladies and Gentlemen: At this time I am extremely proud to present to you my guest speaker for this Eighty-Fifth Annual Convention.

"Dr. Irvine H. Page, of Cleveland, is, I am sure, no stranger to any of you—nor are his many honors and accomplishments. It is superfluous for me to tell you that he is among the truly great men of American and indeed, of world Medicine. Internationally famous, both as a Clinician and as one of the eminent Research Scientists of our time, Dr. Page received his medical education at Cornell Medical College, and ever since his Internship has been closely connected with medical research, directing programs at the Kaiser-Wilhelm Institute in Munich, Germany; at the Rockefeller Institute for Medical Research, and at the Lilly Laboratories. Finally, since 1945 he has been Director of Research and a Member of the Governing Board of the Cleveland Clinic Foundation.

"Author of half a dozen books and innumerable papers on hypertension, arteriosclerosis, and other medical subjects, Dr. Page has served as President of the American Society for the Study of Arteriosclerosis, as well as President of the American Heart Association, and is on the Edi-

torial Board of *Circulation*, *Circulation Research*, and other medical periodicals.

"He is, in short, perhaps the most eminent authority in the world on the subject about which he will speak to you at this time. His topic: 'Ideas on the Mechanism and Treatment of Hypertension'."

(Dr. Page's remarks were extemporaneous and will not be published.)

Dr. Annis: "Thank you, Dr. Page, for a very interesting evaluation of this most important subject."

Dr. Annis: "All of you have, I am sure, heard a great deal recently about the explosions and shake-ups in the Halls of the American Medical Association, and how this has rocked the organization from Washington to Chicago—how heads have fallen and how the house has been cleaned during this past year.

"Here today to speak to you on this 'A.M.A. Reorganization' is the man responsible for it all—the awesome figure who stepped out of our ranks as a practicing physician to assume the position of Wagon Boss of the A.M.A. Train, that Tall Texan, Dr. F. J. L. "Bing" Blasingame, Executive Vice President of the A.M.A.

"Dr. Blasingame."

Dr. F. J. L. Blasingame, Chicago, Executive Vice President, American Medical Association, spoke on "A.M.A. Reorganization." (The address will appear in a future issue of *The Journal*.)

Following Dr. Blasingame's address, the General Session recessed for 10 minutes to visit the exhibits. Three general scientific addresses were then presented: "The Dilemma of Modern Therapeutics," Dr. Ethan Allan Brown, Boston; "Surgical Therapeutics of the Adrenals," Dr. John J. Farrell, Miami, and "Use of Gold in the Treatment of Rheumatoid Arthritis," Dr. L. Maxwell Lockie, Buffalo. (These addresses are scheduled for publication in later issues of *The Journal*.)

The General Session was adjourned at 12:30 p.m.

## First House of Delegates

The House of Delegates convened at 3:20 p.m. on Sunday, May 3, 1959, in the Grand Ballroom of the Americana Hotel, Bal Harbour, Miami Beach, Florida, with President Jere W. Annis in the Chair.

The invocation was pronounced by Dr. Homer L. Pearson Jr., of Miami:

"Almighty God, the source of all life, without whom nothing is strong, nothing is holy, we come to Thee in our finite necessity to seek thy guidance and power in all that we do.

"Be present with us in all the deliberations of this meeting. Keep us humble that we may learn from wiser men and always realize that we do not ever know enough.

"Into our hands Thou hast given the care of life. May we dedicate ourselves body and soul to our calling. Keep far from us the desires of ambition and avarice; give us ready minds and skillful hands that we may serve Thee and Thy creatures, we pray in the name of our blessed Lord, the Healer and Saviour of all men. AMEN."

Dr. Annis: "The Chair wishes to announce that the Parliamentarian for the meeting will be Dr. Joseph S. Stewart.

"I would like to introduce to you the men whom we are apt to forget, the officers of your Association, President-Elect, Dr. Ralph W. Jack; First Vice President, Dr. S. Carnes Harvard; Second Vice President, Dr. Walter E. Murphree; Third Vice President, Dr. Joseph W. Douglas; Secretary-Treasurer, Dr. Samuel M. Day; Editor of The Journal, Dr. Shaler Richardson; and Executive Director, Mr. W. Harold Parham.

"The membership of the Credentials Committee is Dr. Thomas C. Kenaston, Chairman, Dr. Melvin M. Simmons and Dr. Paul F. Baranco. Does this committee have a report ready?"

Dr. Kenaston: "The Credentials Committee wishes to report 173 delegates present out of a possible 186. This constitutes a quorum. I move that the delegates be seated."

Seconded by Dr. Ralph Herz.

Motion carried.

### Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Eugene H. Cummings  
BAY—William C. Roberts, (*Absent*—James A. Poyner)  
BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston  
BROWARD—Miles J. Bielek, Fred E. Brammer, Russell B. Carson, Burns A. Dobbins Jr., Richard L. Foster, Anthony C. Galluccio, Walter J. Glenn Jr., John H.

Mickley, Bernard Milloff, W. Dotson Wells, Scottie J. Wilson

COLLIER—Daniel B. Langley

COLUMBIA—Laurie J. Arnold Jr.

DADE—James L. Anderson, Edward R. Annis, Martin S. Belle, Morris H. Blau, John E. Burch, Chester Cassell, Reuben B. Chrisman Jr., Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Leon S. Eise-man, Franklin J. Evans, Richard M. Fleming, M. Eugene Flipse, Minerva Gordon, Thomas S. Gowin, J. Raymond Graves, Maurice M. Greenfield, W. Tracy Haverfield, James W. Holmes, R. Spencer Howell, James J. Hutson, Christian Keedy, Robert P. Keiser, Alfred G. Levin, Donald F. Marion, John D. Milton, Edwin P. Preston, Warren W. Quillian, George W. Robertson III, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Joseph S. Stewart, Chauncey M. Stone Jr., William M. Straight, Richard E. Strain, Arthur W. Wood Jr., Corren P. Youmans, Nelson Zivitz

DESOTO-HARDEE-HIGHLANDS-GLADES — Gordon H. McSwain

DUVAL—James L. Borland, Frederick H. Bowen, Hugh A. Carithers, Lawrence E. Geeslin, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Gordon H. Ira, Edward Jelks, William J. Knauer Jr., Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, A. Sherrod Morrow, John T. Stage, G. Dekle Taylor, Leo M. Wachtel, Ashbel C. Williams.

ESCAMBIA—Egbert V. Anderson, Paul F. Baranco, Herbert L. Bryans, Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.

FRANKLIN-GULF—(*Absent*—John W. Hendrix)

HILLSBOROUGH—Samuel H. Adams, William C. Blake, Ernest R. Bourkard, Herschel G. Cole, Linus W. Hewit, Samuel G. Hibbs, Eugene B. Maxwell, David R. Murphey Jr., Harold G. Nix, James N. Patterson, Madison R. Pope, Wesley W. Wilson

INDIAN RIVER—James C. Robertson

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—(*Absent*—C. McK. Tyre)

LEE-CHARLOTTE-HENDRY — H. Quillian Jones, (*Absent*—Fred D. Bartleson)

LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—T. Bert Fletcher Jr., Francis T. Holland, Lawrence C. Manni, George S. Palmer

MADISON—Thomas G. Boulard Jr.

MANATEE—Willis W. Harris, Richard V. Meaney

MARION—Henry L. Harrell, Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—Benjamin F. Dickens

ORANGE—Frank C. Bone, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Truett H. Frazier, Fred Mathers, Louis C. Murray, Charles R. Sias, W. Dean Stewart, Miles W. Thomley, Robert L. Tolle, Robert E. Zellner

PALM BEACH—Willard F. Ande, James F. Cooney, Lorenzo James, V. Marklin Johnson, S. Richard Ombres, Ralph M. Overstreet Jr., Cecil M. Peek, Younger A. Staton, A. Scott Turk

PASCO-HERNANDO-CITRUS—Gail M. Osterhout

PINELLAS—Clyde O. Anderson, Elmer B. Campbell Sr., Harry R. Cushman, John P. Ferrell, N. Worth Gable, Percy H. Guinand, Francis H. Langley, Jack A. Macris, J. Braden Quicksall, John P. Rowell, George H. Schoetker, James E. Thompson, Robert T. Walker, Walter H. Winchester, Rowland E. Wood

POLK—Clarence L. Anderson, Marion W. Hester, Edgar B. Hodge, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr.

PUTNAM—Lawrence G. Hebel

ST. JOHNS—Herbert E. White

ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott



SARASOTA—John M. Butcher, Rudolph C. Garber Jr., Samuel E. Kaplan, Melvin M. Simmons

SEMINOLE—Vann Parker

SUWANNEE-HAMILTON-LAFAYETTE — (*Absent* — Shirley L. Hadden)

TAYLOR—(*Absent*—John A. Dyal Jr.)

VOLUSIA—Carroll M. Crouch, C. Robert DeArmas, Achille A. Monaco, Thomas E. Scott Jr.

WALTON-OKALOOSA—Frederic E. Caldwell

WASHINGTON-HOLMES—(*Absent*—Hugh S. Thompson Jr.)

STATE OFFICERS—Jere W. Annis, Ralph W. Jack, S. Carnes Harvard, Walter E. Murphree, Samuel M. Day, Shaler Richardson, (*Absent*—Joseph W. Douglas)

Dr. Annis called attention to a letter in the delegates' portfolios, advising them of \$25,000 accident insurance on all delegates.

Dr. Annis: "At this time it gives me great pleasure to introduce to you the president of the state organization of another profession, which annually sends us its representative. It is difficult to remember not to introduce any McEwan as 'Doctor,' but here today representing The Florida Bar is its president, the Honorable O. B. McEwan, of Orlando."

"President Annis, Distinguished Guests and Members of the Florida Medical Association: It is my pleasure to bring you greetings from the 8,000 lawyers of Florida who are The Florida Bar.

"I believe that I am the first president of The Florida Bar whose father, Dr. John, was President of the Florida Medical Association, whose uncle, Dr. Gaston Edwards, was President and whose cousin, Dr. Duncan McEwan, is a Past President. You can gather from my background that I fully appreciate some of the problems which confront both of our professions, and that I am a strong believer in close cooperation between the members of The Florida Bar and the members of the Florida Medical Association.

"Just recently I received a letter from your president, Jere Annis, stating that your Association has established a standing committee on medical testimony. My understanding of this committee is that it will concern itself with the ethics, morals and veracity of medical testimony given by experts, and will review such testimony upon written request of counsel or the court. There is no doubt in my mind that, in general, physicians strive to give honest and impartial testimony. Members of a learned profession, who are dedicated to the alleviation of the suffering of mankind and to the pursuit of the truths of science, could not do otherwise. This committee will serve a valuable end, both to resolve unfounded charges arising out of an honest difference of opinion, and to provide a forum in those

very rare cases where there may be an element of bias.

"In the same spirit of cooperation, I would like to advise you of the availability of the disciplinary procedures of The Florida Bar. The lawyers of Florida have been entrusted with the maintenance of the highest standards of professional ethics. Under the authority of the Supreme Court of Florida. The Florida Bar has established an official grievance committee in each of the Judicial Circuits of this state. We particularly invite any member of the Medical Profession, who believes that a member of The Florida Bar has acted with impropriety, to lay the facts before the appropriate grievance committee. During the past several years, we have made wonderful progress in the development of relations between members of the Bar and Members of the Medical Profession, and I feel that the one example pointed out here is another valuable step in the development of cordial relations between our professions. I think I can assure you that the lawyers of Florida will always walk arm in arm with the doctors of Florida to cement the relationship between the two most discussed and written about learned professions.

"Jere, Mrs. McEwan and I thank you and the members of the Florida Medical Association for a very pleasant week-end."

Dr. Annis: "Thank you for your remarks and thank you for your cooperation in all the dealings we have with the Bar. At this time we will have to excuse Mr. McEwan because he is on his way to Washington to appear before the Senate Committee in an effort to get the Keogh bill passed."

The members of the House applauded enthusiastically.

Dr. Annis: "At this time I would like to ask for the approval of the minutes of the 1958 Annual Meeting as published in the July 1958 Journal."

On motion duly made, seconded and carried the minutes were approved.

Dr. S. Carnes Harvard, First Vice President, took the Chair.

Dr. Harvard: "Members of the Florida Medical Association, I have come to the one high point for which the First Vice President is elected. I am happy to introduce to you our President, who will make his annual address, and I, personally, think he has done an awfully good job this year."

As Dr. Annis stepped to the rostrum, the House gave a standing ovation.

(The complete text of the Presidential Address appears in this issue on page 21).

The President resumed the Chair.

Dr. Annis: "At this time I would like to recognize our most distinguished native son, and most distinguished member of this organization, the man who has been elected to Medicine's highest honor, Dr. Louis M. Orr, President-Elect of the American Medical Association. Dr. Orr, will you please be seated with the delegates."

The Chair recognized the fraternal delegates from other states, Drs. William R. Carter, President-Elect of the Medical Association of the State of Alabama, and Lee Howard, President, Medical Association of Georgia. (Dr. Howard was not yet present and did not arrive until Wednesday.)

Dr. Annis: "It is now my privilege to introduce to you the representatives of the distaff side of the house who have worked so diligently for our best interests throughout the year. Here to accept the public vote of appreciation, which we most certainly owe our wonderful Auxiliary, are its lovely President, Mrs. Lee Rogers Jr., of Rockledge, and its President-Elect, Mrs. Wendell J. Newcomb, of Pensacola.

"We also have with us Mrs. George Owen, President of the Woman's Auxiliary to the Southern Medical Association."

President Annis introduced to the House Mr. Harry Gray, attorney for the Association.

Dr. Annis: "At this time we will turn to the report of the State Board of Medical Examiners, which will be referred to Reference Committee No. 4. You have a copy of it in your folder and with Dr. Pearson's permission, it will not be read.

"Now we come to a very pressing situation, and one in which it is essential we all understand what we are doing, the election of delegates to the House of Delegates of the American Medical Association. This year we are allotted a fourth delegate. Also, Dr. Orr, by virtue of his office as president-elect of the American Medical Association, has resigned as delegate. These delegates must be elected in such a manner that all the terms will not expire at one time. First, we must elect a replacement for Dr. Orr to serve from now until December 31, 1959; then someone to serve a two year period beginning January 1, 1960 in this same capacity. Then follow the elec-

tion of one member as our fourth delegate and his alternate for a term ending December 31, 1959 and the election of a fourth delegate and his alternate for a two year term beginning January 1, 1960.

"We will first receive nominations for the delegate to replace Dr. Orr for the period from the present time until December 31 of this year."

The Chair recognized Dr. Franklin J. Evans of Dade.

Dr. Evans: "I question whether a delegate must be elected to fill the unexpired term of Dr. Orr. It seems to me that the reason we elect alternates is to fill vacancies caused by the inability of delegates to serve, whether it be for resignation, death or any other cause. It seems that Dr. Orr's alternate should complete his term without the necessity of electing a new delegate. I would like to have a ruling before you call for nominations."

Dr. Annis: "The Chair has considered this and rules that we will *elect* at this time another delegate to the American Medical Association to replace Dr. Orr. The reason for this is that we wish to be absolutely certain that the choice is the choice of this group. We will not fill Dr. Orr's place with the alternate. Do you wish to appeal this ruling?"

Dr. Evans: "I wish to appeal from the ruling of the Chair."

The Chair asked for a standing vote on the question of whether a delegate to replace Dr. Orr should be elected.

The vote was 111 for election of a delegate; 59 against; motion carried.

Dr. Annis: "We will receive nominations for a delegate to replace Dr. Orr."

Dr. Homer L. Pearson Jr.: "In order to save time and a lot of effort, I move that when we are electing delegates to serve from now to December 31, we also elect them for the two year term following."

Motion was duly seconded and carried.

Dr. Annis: "We will now receive nominations for the unexpired term of Dr. Orr and for a two year term as delegate beginning January 1, 1960."

Dr. Edward W. Cullipher of Dade nominated Dr. Meredith Mallory of Orange.

Nomination was seconded by Dr. William C. Roberts of Bay.

Dr. Herbert L. Bryans of Escambia nominated Dr. Sidney G. Kennedy Jr. of Escambia.

Nomination seconded by Dr. Anderson.

Dr. Henry L. Harrell of Marion nominated Dr. Eugene G. Peek Jr. of Marion.

The Chair appointed Drs. Nelson Zivitz, Herbert L. Bryans and Walter H. Winchester as tellers.

Dr. Annis: "While we are balloting, we will proceed with the agenda."

The President read the reference committee appointments.

Dr. Walter W. Sackett Jr. of Dade asked if members who were not present were eligible to serve on reference committees.

Dr. Annis called the roll of reference committee members. All were present except Dr. John V. Handwerker Jr. Dr. Hunter B. Rogers was asked to serve in place of Dr. Handwerker.

#### 1. HEALTH AND EDUCATION

Bermuda Room

Eugene B. Maxwell, Chairman  
Walter J. Glenn Jr.  
Frederick H. Bowen  
Laurie J. Arnold Jr.  
Gordon H. McSwain

#### 2. PUBLIC POLICY

Barbados Room

Henry J. Babers Jr., Chairman  
N. Worth Gable  
Achille A. Monaco  
Robert F. Dickey  
Hunter B. Rogers

#### 3. FINANCE AND ADMINISTRATION

Pan American Room

Herbert E. White, Chairman  
Ralph S. Sappenfield  
James T. Cook Jr.  
Robert L. Tolle  
H. Quillian Jones

#### 4. LEGISLATION AND MISCELLANEOUS

Eastward Room

Edward W. Cullipher, Chairman  
Leo M. Wachtel  
Eugene G. Peek Jr.  
Ralph M. Overstreet Jr.  
George S. Palmer

#### 5. CHARTER AND BY-LAWS

Westward Room

Francis T. Holland, Chairman  
Floyd K. Hurt  
L. Washington Dowlen  
Marion W. Hester  
Madison R. Pope

The following committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented:

#### (To Reference Committee No. 1)

Scientific Work, Lawrence E. Geeslin  
Medical Postgraduate Course, Turner Z. Cason  
Venereal Disease Control, Lorenzo L. Parks  
\*Tuberculosis and Public Health, Hawley H. Seiler  
Maternal Welfare, E. Frank McCall  
\*Child Health, Warren W. Quillian  
Cancer Control, Robert F. Dickey  
Resolution—School Bus Drivers' Examinations  
Resolution—Tetanus toxoid immunization

Resolution—Admission of cancer patients under Indigent Hospitalization Program without prerequisite of tumor clinic approval

#### (To Reference Committee No. 2)

\*Conservation of Vision, Marion W. Hester  
\*Medical Education and Hospitals, Jack Q. Cleveland  
\*Medical Economics, S. Carnes Harvard  
\*Representatives to Industrial Council, P. G. Batson Jr.  
Grievance, Frederick K. Herpel  
\*Nursing, Thomas C. Kenaston  
Blood, James N. Patterson  
Resolution—Liaison Committee with State Board of Health  
Resolution—Life Insurance Examinations  
Resolution—Insurance Examination Fees  
Resolution—Standardized Insurance Claim Forms  
Resolution—Hospital Accreditation

#### (To Reference Committee No. 3)

Address of President, Jere W. Annis  
\*Board of Governors, Jere W. Annis  
\*Necrology, Leo M. Wachtel  
Advisory to Woman's Auxiliary, L. Washington Dowlen  
\*Councilor Districts and Council, Warren W. Quillian  
Advisory to Selective Service, J. Rocher Chappell  
Civil Defense and Disaster, W. Dean Steward  
\*Advisory to Blue Shield, Henry J. Babers Jr.  
\*Medicare Mediation, Burns A. Dobbins Jr.  
Resolution—Medicare Contract  
Resolution—FMA Certificate of Merit  
Resolution—Nomination of Edward Jelks, M.D. to receive first Certificate of Merit  
Resolution—Health Insurance for People over 65 at reduced rates  
Resolution—Essay Contest  
Resolution—Free Choice of Physician

#### (To Reference Committee No. 4)

\*Legislation and Public Policy, H. Phillip Hampton  
Mental Health, Sullivan G. Bedell  
State Controlled Medical Institutions, William D. Rogers  
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.  
Aging, Samuel Gertman  
Delegates to AMA: Louis M. Orr, Reuben B. Chrisman Jr., and Francis T. Holland  
Report of Secretary, State Board of Medical Examiners, Homer L. Pearson Jr.  
Resolution—Social Security for Physicians  
Resolution—Training Center for Retarded Children  
Resolution—Selection of Physicians Participating in Rehabilitation Program  
Resolution—Physician membership of Boards, commissions and advisory committees  
Resolution—Privileged Communications  
Resolution—Medical Practice Act—Interns and Residents

#### (To Reference Committee No. 5)

Proposed Charter and By-Laws  
Resolution—Amendment to proposed Charter and By-Laws—Public Relations  
Resolution—Amendment to proposed Charter and By-Laws—Committee of 17  
Resolution—Amendment to proposed Charter and By-Laws—Board of Governors  
Resolution—Changes and objections to proposed Charter and By-Laws  
\*Supplemental reports included.

Dr. Annis: "By your ballot, you have elected Dr. Meredith Mallory as your delegate to the American Medical Association."

Dr. Mallory: "I do indeed appreciate your selecting me. I thank you from the bottom of



my heart. I do want to serve you again in the House of Delegates of the American Medical Association. I will do my very best for Florida. Again, I thank you."

Dr. Annis: "At this time we will accept nominations for alternate to Dr. Mallory for a two year term from January 1, 1960 to December 31, 1961. He has an alternate for this year, Dr. Richard A. Mills."

Dr. Ralph Herz nominated Dr. Eugene G. Peek Jr. as alternate.

As there were no other nominations, it was moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot for Dr. Peek.

Motion carried.

The Chair called for nominations for the fourth delegate for the remainder of 1959 and for a two year term beginning January 1, 1960.

Dr. Homer L. Pearson Jr. nominated Dr. Madison R. Pope of Hillsborough.

Dr. George S. Palmer nominated Dr. Burns A. Dobbins Jr. of Broward.

Dr. Henry J. Babers Jr. nominated Dr. Walter E. Murphree of Alachua.

Dr. Achille A. Monaco nominated Dr. C. Robert DeArmas of Volusia.

Dr. Annis: "Before Dr. Murphree can accept this nomination, he will have to resign as alternate to Dr. Holland, as he cannot hold both offices."

Dr. Murphree tendered his resignation, which was accepted by the Chair.

Dr. Franklin J. Evans asked whether the elections were being decided on a plurality basis or a majority basis.

Dr. Annis: "On a majority basis. The Chair will assume it will take a majority to elect. Is it your will that if one candidate does not secure a majority, we ballot again on the three high men?"

Dr. Zellner: "I move that we vote on the number which constitutes a majority of votes cast; if it is two, we will vote on two."

Seconded by Dr. Roberts.

Dr. Annis: "It has been moved and seconded that if no one candidate receives a majority of votes cast, we vote on the smallest number comprising a majority."

Motion carried.

On the first ballot, the count was Dobbins 75, Murphree 52, Pope 32, DeArmas 8, and a second ballot was taken.

Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy, read his supplemental report, which was referred to Reference Committee No. 4.

Dr. Burns A. Dobbins Jr., Chairman, Medicare Mediation Committee, read a supplemental report, which was referred to Reference Committee No. 3.

Dr. Annis introduced Lt. Col. E. G. Rivas, of the Office for Dependents' Medical Care. Mr. H. A. Schroder, Executive Director of Blue Shield, and Mr. N. G. Johnson, Claims Consultant and Medicare Coordinator of Blue Shield.

Dr. Hawley H. Seiler, Chairman, Tuberculosis and Public Health Committee, read a supplemental report, which was referred to Reference Committee No. 1.

The President introduced Dr. Norman Welch, Vice Speaker of the House of Delegates of the American Medical Association, and past chairman of the National Blue Shield Commission, and Dr. Russell B. Carson, President of Blue Shield of Florida.

On the second ballot, the results were Dobbins 106 and Murphree 59.

The Chair announced that Dr. Burns A. Dobbins Jr. was elected fourth delegate.

The Chair asked for nominations for alternate delegate to Dr. Dobbins for the remainder of this year and for a two year term beginning January 1, 1960.

Dr. Evans nominated Dr. Walter E. Murphree.

Dr. Ralph Herz moved that nominations be closed.

Motion seconded and carried.

Dr. James L. Borland moved that Dr. Murphree be elected as alternate to Dr. Dobbins.

Motion seconded and carried.

The Chair asked for nominations for alternate to Dr. Francis T. Holland to take Dr. Murphree's place.

Dr. Zellner nominated Dr. Madison R. Pope of Hillsborough.

It was moved and seconded that nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Pope.

Motion carried.

Dr. Annis asked if there were any other supplemental reports from committees.

Dr. Kenaston: "The Credentials Committee wishes to report there are now 178 delegates present and seated out of a possible 186."

Dr. Miles J. Bielek presented a resolution by the Broward County Medical Association regarding Blue Shield, Blue Cross and Commercial insurance companies providing continued coverage for persons after age 65. This was referred to Reference Committee No. 3.

Dr. R. Spencer Howell presented a resolution regarding the essay contest for high school students, which was referred to Reference Committee No. 3.

Dr. Richard F. Sinnott presented a resolution by the St. Lucie-Okeechobee-Martin County Medical Society, regarding the care of indigent cancer patients, which was referred to Reference Committee No. 1.

Dr. Walter W. Sackett Jr., of Dade presented a resolution by the Florida Academy of General Practice regarding free choice of physician, which was referred to Reference Committee No. 3.

Dr. Annis read a list of members of the Florida Medical Association who had achieved special recognition during the past year.

Grover W. Austin, M.D., St. Petersburg, was elected treasurer of the Southeastern Society of Plastic and Reconstructive Surgeons at its organizational meeting in New Orleans in April 1958.

Ashbel C. Williams, M.D., Jacksonville, was elected a member of the National Board of Directors of the American Cancer Society at its regular meeting in Memphis. Dr. Williams will represent Region III, which covers the Southeastern states, for a two year term.

Erasmus B. Hardee, M.D., Vero Beach, was elected to the six man Executive Committee of the National Board of Medical Examiners in May 1958.

J. Maxey Dell Jr., M.D., Gainesville, was elected Councilor of the Radiological Society of North America last summer.

M. Jay Flipse, M.D., Miami, was elected First Vice President of the American College of Chest Physicians last summer.

Milton M. Coplan, M.D., Miami, was elected President of the AMA's Section on Urology last summer.

Ralph S. Sappenfield, M.D., Miami, served as President of the American Society of Anesthesiologists in 1958.

Chas. J. Collins, M.D., Orlando, served as President of the South Atlantic Association of Obstetricians and Gynecologists in 1958.

Wilson T. Sowder, M.D., State Health Officer, Jacksonville, was named to the Executive Committee of the American Public Health Association at its meeting in St. Louis on October 31, 1958.

Joseph J. Lowenthal, M.D., Jacksonville, assumed the presidency of the Florida Diabetes Association at its sixth annual meeting on October 30 and 31 in Bal Harbour, Miami Beach.

Frederick E. Manulis, M.D., Palm Beach, was elected a Governor of the American College of Gastroenterology at its annual meeting in New Orleans on October 20, 1958.

DeWitt C. Daughtry, M.D., Miami, was elected Second Vice President of the Southern Chapter, American College of Chest Physicians, at its fifteenth annual meeting in New Orleans, November 2 and 3, 1958.

Charles McC. Gray, M.D., Tampa, has recently been elected Vice President of the American College of Radiology. He has just completed a four year term as a member of its Board of Chancellors.

Leonard G. Rowntree, M.D., Miami, is reaping honors as a result of his 50 years of medical practice. An annual Leonard G. Rowntree Lecture has been established at the University of Miami School of Medicine by the Phi Beta Pi Medical Fraternity in tribute to Dr. Rowntree's role in helping found the School of Medicine. Dr. Paul Dudley White delivered this year's lecture. Among his other achievements, Dr. Rowntree developed the first artificial kidney and pioneered in the study of the adrenal and other endocrine glands.

Ralph W. Jack, M.D., Miami, was elected Second Vice President of the American College of Obstetricians and Gynecologists.

S. Carnes Harvard, M.D., celebrated 25 years of practice in Brooksville.

George R. Creekmore, M.D., has practiced in Brooksville for 42 years.

Julius C. Davis, M.D., Quincy, has been in practice for 50 years in this location.

Frederick H. Bowen, M.D., Jacksonville, was elected a Governor of the American College of Surgeons.

Charles K. Donegan, M.D., St. Petersburg, was elected to the Board of Trustees, American Society of Internal Medicine.

The President announced that each delegate would find a ticket to the President's Reception stapled to his folder and that committee chairmen and others who were not delegates, but who customarily receive complimentary tickets, could pick them up at the registration desk.

The House of Delegates recessed at 5:18 p.m. to reconvene at 9:30 a.m. on Wednesday, May 6, 1959.

## Second House of Delegates

The House of Delegates reconvened at 9:50 a.m. on Wednesday, May 6, 1959, in the Grand Ballroom of the Americana Hotel, Bal Harbour, Miami Beach, President Jere W. Annis presiding.

Dr. Kenaston reported that 150 delegates were present, constituting a quorum, and moved that the delegates be seated.

Motion seconded and carried.

### Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Eugene H. Cummings  
BAY—William C. Roberts, (*Absent—James A. Poyner*)  
BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston  
BROWARD—Miles J. Bielek, Fred E. Brammer, Russell B. Carson, Burns A. Dobbins Jr., Richard L. Foster, Anthony C. Galluccio, Walter J. Glenn Jr., John H. Mickley, W. Dutton Wells, Scottie J. Wilson, (*Absent—Bernard Milloff*)  
COLLIER—(*Absent—Daniel B. Langley*)  
COLUMBIA—Laurie J. Arnold Jr.  
DADE—James L. Anderson, Edward R. Annis, Morris H. Blau, John E. Burch, Chester Cassell, Reuben B. Chrisman Jr., Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, M. Eugene Flipse, Minerva Gordon, J. Raymond Graves, Maurice M. Greenfield, James W. Holmes, R. Spencer Howell, Robert P. Keiser, Alfred G. Levin, Donald F. Marion, John D. Milton, Edwin P. Preston, Warren W. Quillian, George W. Robertson III, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Joseph S. Stewart, Chauncey M. Stone Jr., William M. Straight, Richard E. Strain, Arthur W. Wood Jr., Nelson Zivitz, (*Absent—Martin S. Belle, Leon S. Eisenman, Richard M. Fleming, Thomas S. Gowin, W. Tracy Haverfield, James J. Hutson, Christian Keedy, Corren P. Youmans*)  
DESOTO-HARDEE-HIGHLANDS-GLADES — Gordon H. McSwain  
DUVAL—James L. Borland, Frederick H. Bowen, Hugh A. Carithers, Lawrence E. Geeslin, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Gordon H. Ira, Edward Jelks, William J. Knauer Jr., Charles F. McCrory, Kenneth A. Morris, A. Sherrod Morrow, John T. Stage, G. Dekle Taylor, Leo M. Wachtel, Ashbel C. Williams, (*Absent—Joseph J. Lowenthal*)  
ESCAMBIA—Egbert V. Anderson, Paul F. Baranco, Herbert L. Bryans, Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.  
FRANKLIN-GULF—(*Absent—John W. Hendrix*)  
HILLSBOROUGH—Samuel H. Adams, William C. Blake, Ernest R. Bourkard, Linus W. Hewit, Samuel G. Hibbs, Eugene B. Maxwell, David R. Murphey Jr., Harold G. Nix, James N. Patterson, Madison R. Pope, Wesley W. Wilson, (*Absent—Herschel G. Cole*)  
INDIAN RIVER—James C. Robertson  
JACKSON-CALHOUN—James T. Cook Jr.  
LAKE—(*Absent—C. McK. Tyre*)  
LEE-CHARLOTTE-HENDRY—Fred D. Bartleson, H. Quillian Jones  
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—T. Bert Fletcher Jr., Francis T. Holland, Lawrence C. Manni, George S. Palmer  
MADISON—Thomas G. Boulard Jr.  
MANATEE—Willis W. Harris, Richard V. Meaney

MARION—Henry L. Harrell, Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—Benjamin F. Dickens

ORANGE—Frank C. Bone, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Truett H. Frazier, Fred Mathers, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert L. Tolle, Robert E. Zellner, (*Absent—Louis C. Murray*)

PALM BEACH—Willard F. Ande, James F. Cooney, V. Marklin Johnson, Ralph M. Overstreet Jr., Cecil M. Peek, A. Scott Turk, (*Absent—Lorenzo James, S. Richard Ombres, Younger A. Stalon*)

PASCO-HERNANDO-CITRUS—Gail M. Osterhout

PINELLAS—Clyde O. Anderson, Elmer B. Campbell Sr., Harry R. Cushman, John P. Ferrell, N. Worth Gable, Percy H. Guinand, Francis H. Langley, Jack A. MacCris, John P. Rowell, George H. Schoetker, James E. Thompson, Robert T. Walker, Walter H. Winchester, Rowland E. Wood, (*Absent—J. Braden Quicksall*)

POLK—Clarence L. Anderson, Marion W. Hester, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr., (*Absent—Edgar B. Hodge*)

PUTNAM—Lawrence G. Hebel

ST. JOHNS—Herbert E. White

ST. LUCIE-OKEECHOBEE-MARTIN — Richard F. Sinnott

SARASOTA—John M. Butcher, Rudolph C. Garber Jr., Samuel E. Kaplan, Melvin M. Simmons.

SEMINOLE—Vann Parker

SUWANNEE-HAMILTON-LAFAYETTE — (*Absent—Shirley L. Hadden*)

TAYLOR—John A. Dyal Jr.

VOLUSIA—Carroll M. Crouch, C. Robert DeArmas, Achille A. Monaco, Thomas E. Scott Jr.

WALTON-OKALOOSA—Frederic E. Caldwell

WASHINGTON-HOLMES—(*Absent—Hugh S. Thompson Jr.*)

STATE OFFICERS—Jere W. Annis, Ralph W. Jack, S. Carnes Harvard, Walter E. Murphree, Joseph W. Douglas, Samuel M. Day, Shaler Richardson.

Dr. Annis introduced Dr. Lee Howard, President, Medical Association of Georgia, and Dr. Charles C. Cooper, of St. Paul, former Vice President of the American Academy of General Practice.

Dr. Annis: "At this time, Dr. Day has the pleasant task of presenting the Life Membership certificates."

Dr. Day: "As Dr. Annis has said, it is always a pleasure to be able to present the Life Membership certificates to those who have been members of our Association for 35 years. I will ask them to come up to the front as their names are called."

Dr. Day: "Dr. Kenneth A. Morris is the only one present. The certificates will be mailed to the others."

Dr. Annis: "At this time, we will have the report of the representative to the Student American Medical Association, John F. Mason Jr. of the University of Florida."



## Student American Medical Association Convention Report of Delegate

JOHN F. MASON Jr.

COLLEGE OF MEDICINE, UNIVERSITY OF FLORIDA

President Annis, Officers and Members of the Florida Medical Association:

I wish to express my gratitude for the opportunity to come before you and report on the activities of the 1959 Convention of the Student American Medical Association. It was only through the generosity of the Florida Medical Association that the S.A.M.A. Chapters of the University of Florida and the University of Miami were able to send delegates to Chicago for this meeting.

Before I report on the convention, I would like to give an explanation to those of you who are not acquainted with S.A.M.A.—what it is and why it exists. S.A.M.A. is the voice of the majority of medical students in the United States. Seventy-four of the 80 American medical schools have S.A.M.A. Chapters. I want to say a few words about the other six later.

To quote from the S.A.M.A. Constitution: "The object of this association shall be to advance the profession of medicine, to contribute to the welfare and education of medical students, interns and residents, to familiarize the members with the purposes and ideals of organized medicine, and to prepare its members to meet the social, moral, and ethical obligations of the profession of medicine."

S.A.M.A. was organized nine years ago and has grown steadily ever since. Initially under the parental and fiscal sponsorship of the American Medical Association, S.A.M.A. is now an autonomous organization with its own offices, Executive Director Russ Staudacher, and full time staff. Our funds come from dues, technical exhibits at the convention and advertising in our monthly journal, "The New Physician," which is directed to the needs of the physician-in-training.

Just a word about the national organization of S.A.M.A. The 74 member schools are divided among eight geographical districts. It is noteworthy that the schools of our region—those in North and South Carolina, Virginia, Georgia, Alabama, and Florida—are the most active and best organized of any region in the country. All 13 schools in this area are members of S.A.M.A. and 12 had delegates at the Convention. No other region comes anywhere near this. Two other Southern schools are also very active, the University of Texas in Galveston, and the University of Oklahoma. Last year's national president was E. Carwile Leroy, of North Carolina; this year's is William Kirkham, of Oklahoma.

The Ninth Annual S.A.M.A. Convention met at the Sheraton Hotel in Chicago, April 29 through May 3. Our total registration was over 1,700, a number that compares favorably with the registration at this convention.

It is difficult to evaluate our meeting, for the myriad caucuses, committee meetings, formal and information "bull sessions" have not yet quite been digested. Then too, time does not permit an enumeration of all that happened and a full report of the proceedings will appear in the June issue of "The New Physician." I can only try to give a resume of the proceedings, legislation and problems which seem most important to me as an individual, a Floridian, and a proponent of organized medicine.

Our 1959 House of Delegates introduced, referred to committees, discussed and voted on 16 proposals relating to scholarship funds, evaluation of internships, state medical examination boards and the National Intern Matching Plan. It is significant that the House of Delegates rejected overwhelmingly a proposal that we affiliate with the loose-knit International Federation of Medical Students.

One problem that was discussed that confronts our organization is obtaining funds for the S.A.M.A. Founda-

tion. The stumbling block seems to be that we cannot get any money for scholarship loans until the Foundation is declared nonprofit and contributions are tax-deductible. But we face the same problem as the Florida Medical Foundation in that we cannot be declared tax-deductible until we have money in the bank. I hope someone solves this problem soon.

Aside from the policy making, this is the first year that we have had a first class scientific session. Of 40 papers, eight were chosen to be presented. The topics of this student research varied from "Pulmonary Hyaline Membrane, Etiology and Pathogenesis" to "Relationship of Mental and Emotional Stress to Serum Cholesterol Levels." On the second day, three papers were presented by interns and residents. There were 40 technical exhibits and 20 scientific exhibits by students, interns and residents.

Either of the guest speakers would do credit to this or any other state convention. Dr. Corbett Thigpen, psychiatrist at the University of Georgia and co-author of "The Three Faces of Eve," held a packed, hot ballroom spellbound for two hours with his discussion of "Multiple Personality."

Equally outstanding was Dr. Alton Ochsner's presentation of "Smoking and Its Relationship to Lung Cancer." This may be "old hat" to some of you who have heard him many times, but to us it was quite stimulating.

The little time I have left I would like to devote to a problem S.A.M.A. faces and which concerns you all as active members of organized medicine. The future doctors of America are gaining their concept of organized medicine in the Student American Medical Association. Not all students at the member schools belong to S.A.M.A., but it is strange that the only six schools which do not have S.A.M.A. Chapters are clustered in the Northeast. These are some of the oldest and best established medical schools in the country, whose graduates have been outstanding in organized medicine—Harvard, Columbia, Cornell, Yale, Johns Hopkins and Vermont. Efforts have been made to contact these schools and interest them in joining our association; this year Vermont sent observers to our convention. The other five schools have either ignored or violently opposed our invitations. We can only conclude that either they consider S.A.M.A. unworthy of notice or they are just not interested in organized medicine.

The future of the private practice of medicine in America rests with its medical associations. For graduates of these fine schools to enter the practice of medicine either ignorant or opposed to organized medicine is not only tragic, but dangerous. It is as if the doctors of Florida were to deny the existence and value of the American Medical Association. Those of us who are interested in the future of medicine had better take notice.

Dr. Annis: "Also just arrived is Mr. Charles Farmer, Student A.M.A. representative of the University of Miami."

## Report of the S.A.M.A. National Convention To the Florida Medical Association

CHARLES B. FARMER

DELEGATE

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

It is with a great deal of gratitude and humility that I make this report to the House of Delegates of the Florida Medical Association. Because of your generosity and genuine interest in the future physicians of this state, it was possible for me and the alternate delegate from Miami, Paul Kmiecik, to represent the University of Miami and the State of Florida at the National S.A.M.A. Convention.

It was my first convention, and I must admit that I went not knowing quite what to expect.

I came away from that convention convinced that



it served a useful purpose, and I think a great deal was accomplished by it.

At the convention I was privileged to serve on the Nominating Committee composed of six members and a chairman. It was our task to single out those best qualified to hold a national office. It was rather intriguing because the identity of the members of the committee was not made known to the House of Delegates. It proved to be a very busy job, but it afforded me an opportunity to look closely at a cross section of medical students, from across these great United States. I was inspired by the quality of these young men. Excellence was their standard. We found that most of the delegates could qualify for any job and this made our task a little more difficult. The delegate from the University of Florida was considered for a national office, and I suggested the names of some other men from our Southern Region I. As you know, Southerners are traditionally the best leaders of men.

In the course of our convention, we were privileged to hear from such fine doctors as Dr. Fount Richardson, President-Elect of the A.A.G.P., Dr. Alton Ochsner of New Orleans, and Dr. Corbitt Thigpen of the University of Georgia. There were Scientific Exhibits and Photography Clinics, and there were 41 Technical Exhibitors. Total registration for the three days was in excess of 1,700. Some of the business conducted will be considered briefly:

The committee on Medical Education proposed plans for introducing the Medical Schools to the pre-med. and senior high school students in the form of a medical career day with tours, lectures, and exhibits. This is to stimulate and preserve an early interest in medicine and to channel the best minds into the study of medicine. This has been very successful in many of the Mid-western and Eastern schools.

To further the study and evaluation of Preceptorships. These are available in 21 medical schools at this time.

An Intern and Resident Economic Evaluation Survey is underway to compile data on their respective financial status.

Resident Evaluation for Residency Programs are being collected and a resident-matching program similar to the S.A.M.A. inspired National Intern Matching Program is under consideration. Under the latter program, it is noteworthy that last year 80 per cent of seniors were assigned to their first choice for internship.

A move is underway to have the S.A.M.A. monthly journal, *THE NEW PHYSICIAN*, indexed in the Index Medicus by the National Library of Medicine. At present, *THE NEW PHYSICIAN* is seventh in circulation among all journals in the United States.

An insurance plan to cover medical equipment, such as microscopes, is being investigated to supplement the S.A.M.A. Life, Major Medical, and Malpractice policies for its members.

A resolution was made to investigate "some medical examining boards composed of cultists as well as Doctors of Medicine—whereas there appears to be a trend away from board members with a strong clinical background toward members more academically grounded." This was not considered feasible, however, and it was defeated.

In a short period of nine years of growth and development, S.A.M.A. has accomplished a great deal and has served a good purpose.

In five years the University of Miami S.A.M.A. has matured rapidly and it serves 100 per cent of the student body. Cooperation such as we have had from the F.M.A. has made this growth possible.

On behalf of the University of Miami, School of Medicine, I want to thank you again.

Dr. Annis: "The Florida Medical Association will have a hospitality room open from 5 to 7 p.m. on Monday and Tuesday, June 8 and 9, at the Traymore Hotel in Atlantic City. Association members are invited to come and assist with our hospitality to the other states.

"Dr. Orr's inaugural ceremony will be at 8 p.m. on Tuesday, June 9, and the Florida Medical Association's reception honoring Dr. and Mrs. Orr will be from 5:30 to 7:30 p.m. at the Traymore Hotel, Wednesday, June 10."

Dr. Annis announced that Dr. Robert G. Gilbert of Coral Gables had the low gross score in the Golf Tournament and had been awarded the Duval Cup; Dr. Lester A. Russin, of Miami Beach, won the Orlando Cup for low net score.

Dr. Robert F. Dickey, chairman of the Anglers' Committee announced that there had been no entries in the fishing contest.

Dr. Annis: "I have asked Dr. Jack as the first order of business after he takes office to call this House into executive session for a short time, to enable me to say something that I did not feel I should say in open meeting. We will now proceed with the recommendations of the reference committees."

## Report of Reference Committee No. 1

### Health and Education

Dr. Eugene B. Maxwell: "Mr. President and Members of the House of Delegates: Your Reference Committee on Health and Education composed of Drs. Walter J. Glenn Jr., Frederick H. Bowen, Laurie J. Arnold Jr., Gordon H. McSwain, and myself as Chairman, met and considered the reports of the various committees and make the following report:

"The report of the Committee on Scientific Work as presented by Lawrence E. Geeslin, M.D.,

Chairman, is approved as printed in the Handbook. In addition, the Reference Committee further recommends that funds be designated by the Board of Governors to cover travel and living expenses for guest speakers.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward.

Motion carried.

## Report of Committee on Scientific Work

LAWRENCE E. GEESLIN, *Chairman*

In an effort to stimulate greater interest in the scientific activities of the Association, to provide the opportunity for wider participation by members in the preparation of the Annual Meeting program, and to present the best possible program, the Committee on Scientific Work recommends:

1. That the officers of the various specialty societies decide upon their guest speakers prior to December 15 of each year and that the names of these speakers be sent to the Chairman of the Committee on Scientific Work in order that he and the members of his committee may be informed and also may utilize the talent of these guest speakers on the Annual Meeting program;
2. That a questionnaire be published in *The Journal* requesting the members of the Association to submit the scientific subjects they would prefer discussed on the Annual Meeting program, and that these subjects be reviewed by the Committee on Scientific Work and published in *The Journal* with the request that any member desiring to discuss any one subject submit an abstract for consideration by the Committee;
3. Since the discontinuance of the annual banquet leaves an opening Tuesday evening, it is suggested that two alternative possibilities be considered in the future:
  - a. That the evening be set aside for the address by the President's guest speaker rather than have him appear on the program of the general scientific session;
  - b. Should one of the visiting guest speakers of the general scientific assembly be of such unusual prominence nationally, that the possibility be considered of inviting him to present an outstanding address on Tuesday evening which would not only allow a longer talk than the usual 20 minutes, but would provide an opportunity for the members to meet with him informally after his address.

These suggestions are considered, of course, should the specialty groups not avail themselves of this Tuesday evening time which has been available this year for the first time.

It is further urged that the Board of Governors continue the same yearly allotment for use by the Scientific Work Committee for travel and living expenses for prominent guest speakers.

The Committee met in Jacksonville on November 9 to review the abstracts of papers and descriptions of scientific exhibits proposed for the program of the 1959 Annual Meeting. There was a wealth of material and the Committee is grateful for the response to its requests published in *The Journal* and in "Briefs." A total of 36 abstracts had been submitted, and it was possible to include only about one-third this number on the program. Members were prompt to send their abstracts and titles and this made a portion of the work easier for the Committee.

The quality of the proposed papers was excellent and the rejection of an abstract was due to the fact that it did not fit into the type of scientific program the Committee desired to present. It is hoped that members who did not get on the program will prepare their papers and submit them to *The Journal* for possible publication anyway.

Because of the lack of a theatre in the hotel, it was decided not to have a scientific film program this year. There was some interest, however, and future Scientific Work Committees may desire to again institute this feature.

It is suggested that members of the Association continue to plan well in advance for their papers, exhibits and films in order that titles, abstracts and descriptions may be submitted in the fall. The Committee can meet the middle of November and decide upon the complete program with all participants notified by the middle of January. This plan eliminates much of the rush in early

spring to get the program completed for publication in *The Journal*.

It is recommended that funds be designated by the Board of Governors to cover travel and living expenses for guest speakers.

Dr. Maxwell: "The report of the Committee on Medical Postgraduate Course presented by Dr. Turner Z. Cason, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion duly seconded and carried.

## Report of Committee on Medical Postgraduate Course

TURNER Z. CASON, *Chairman*

The Committee on Medical Postgraduate Course met at the Florida Medical Association Building in Jacksonville on March 16, 1958. No other meeting of this Committee was held during the past year. A majority of the membership was present. In addition to the members of the Committee, Dr. George T. Harrell, Dean of the College of Medicine, University of Florida; Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine, and Dr. William C. Thomas Jr., head of the Division of Postgraduate Education of the College of Medicine of the University of Florida, were present.

Inasmuch as the Division of Postgraduate Education of the College of Medicine of the University of Florida had taken over many of the functions of this Committee, the Chairman presented the question of the future needs and activities of the Committee. The first question considered was whether or not there was further need for the Committee. In this discussion, the Deans of the two medical schools took part and voted with the Committee. It was unanimously decided that the Committee should be continued, and its functions were outlined as follows:

1. To represent the Association in sponsoring postgraduate courses
2. To offer advice and coordination to prevent duplication of effort
3. To do a certain amount of investigation
4. To publicize courses and encourage physicians to undertake postgraduate courses

At the request of the Committee, the Chairman appeared before the designated reference committee at the Association's Annual Meeting held in Bal Harbour in May of 1958.

It is the opinion of the Chairman that a passive attitude is of little value and the Committee, in consequence, is not utilized as it could and should be. It is suggested that the Committee hold another meeting sometime within the next few months, and at that time certain plans should be made to reactivate its functions. All county medical societies and other organizations sponsoring postgraduate education should be reminded that the Committee continues to exist, that it is now functioning entirely in cooperation with the Florida Medical Association, and that it is most anxious to prevent duplication of effort and time in the presentation of graduate medical education in Florida. After a year of relative silence it appears that the Committee was correct in its opinion when it met in March of 1958, and that it should resume activities.

Dr. Maxwell: "The report of the Committee on Venereal Disease Control presented by Dr.



Lorenzo L. Parks, Chairman, is approved as printed in the Handbook.

“Mr. President, I move the adoption of this portion of the report.”

Seconded by Dr. Fred Mathers.

Motion carried.

### Report of Committee on Venereal Disease Control

LORENZO L. PARKS, *Chairman*

There were no Committee meetings during the year. Members of the Committee were contacted by mail. We have asked the Division of Venereal Disease Control, Florida State Board of Health, to evaluate the progress during the past ten years on the control of venereal diseases.

Their study indicates a marked decline in the over-all venereal disease problem as reflected by the following figures:

Year	Total Syphilis	Rate Per 100,000 Population	
		Primary & Secondary	Total Syphilis
1958	3,186	201	71.0
1949	12,363	2,370	459.2

Many factors are responsible for the difference in the rates for this ten-year span. During the years immediately following World War II it was not uncommon to find clinical venereal disease cases without laboratory confirmation, no epidemiological investigation, and inadequate treatment schedule until the early 1950's. Many public health officers and private physicians were still using the old standard 18 month treatment for syphilis or a combination of old therapy and penicillin at that time. Hence, many patients were rediagnosed, retreated, and counted as morbidity cases again and again.

The State Board of Health, with the close cooperation of the private physician, is striving to recognize the present venereal disease problem as one of correct diagnosing, good epidemiology and proper treatment of all venereal disease patients and suspects.

No mass serology surveys were conducted last year as compared with previous years. Although there has been a marked decline in morbidity rates for syphilis, the rates for primary and secondary syphilis cases have remained approximately the same during the past three years.

The group of other venereal diseases reported include chancroid, granuloma inguinale and lymphopathia venerea. The following figures show a decline in the number of cases reported.

Year	Chancroid	G. I.	L. V.
1958	188	47	42
1949	343	827	127

As with other venereal diseases, the age group chiefly affected is young adults. The largest number of cases is reported in the age group 15-24 for each disease.

Evaluation continues to be a challenge in the measure of control of the venereal disease problem. Since immunizing agents are not available, control depends upon the elimination of the reservoir of infection by the proper treatment of known cases, and the education of the public in preventive measures. Education must be placed and recognized in its proper long term perspective program if we are to eventually reach the maximum in venereal disease control.

An evaluation of the premarital, prenatal and health card laws, which require a serological test for syphilis, indicates a continuance of these for the immediate future.

Gonorrhea continues to be a problem since it is not well reported. In 1949 there were 15,388 cases reported, or a rate of 571.5 per 100,000. In 1958 there were 10,372

cases, or a rate of 244 per 100,000. Approximately one-half of the syphilis cases reported are by the private physician, and most of the primary and secondary syphilis cases are interviewed by the private physician or trained public health interviewer-investigator. The cooperation on the part of the physicians in the reporting of syphilis is shown in the control of the early infectious cases. The use of trained public health personnel in the fields of epidemiology continues to be the main factor in controlling the spread of syphilis. The same policies should be given to the control of gonorrhea.

Cluster testing, or the testing of one's associates, has been devised as a new technique in finding early syphilis. This method of locating additional syphilis cases is by interviewing the early syphilis case for persons other than sex contacts after the initial interview for such contacts has been concluded. These suspects and/or associates may include actual sex contacts, such as married partners, homosexuals and others which the known case finds less embarrassing to name. These persons are called suspects and investigations are made on them as well as others. These suspects must be sold on the idea of being examined, including a serology. Selective bloodtesting is done among this group and their associates who are included in the same social group at home or in the same community. This method is being used successfully to find and locate previously unreported cases of early infectious syphilis. It requires skill and perseverance on the part of the venereal disease interviewer-investigator, and he often must work hours beyond the normal working hours.

The cooperation of the physician and health authorities of the state for the past year has shown what can be done in the control of syphilis, and the same is recommended for the control of the other venereal diseases, and in particular for gonorrhea.

Dr. Maxwell: “The report of the Committee on Tuberculosis and Public Health presented by Dr. Hawley H. Seiler, Chairman, is approved as printed in the Handbook. In addition, the Committee approves the first Supplemental Report with the recommendation that Paragraph III be amended to read as follows: ‘WHEREAS, destructive legislation based upon this report has been recommended in the current session of the Legislature, and.’ Supplement Report No. 2 pertaining to fluoridation of public water supplies in Florida is approved.

“Mr. President, I move the adoption of this portion of the report as amended.”

Seconded by Dr. David R. Murphey Jr.

Motion carried.

### Report of Committee on Tuberculosis and Public Health

HAWLEY H. SEILER, *Chairman*

The Committee on Tuberculosis and Public Health has had no meetings during the year 1958-1959, and no calls for Committee action have been received by your chairman. Last year's project concerning the availability of routine chest x-rays, electrocardiograms, and other laboratory tests for physicians at the annual FMA meeting was carried to completion. The following indicates the number of tests performed on the physicians visiting the exhibit:

Total number of physicians to visit exhibit and have one or more tests made	109
Total number of EKGs made	75

Total number of chest x-rays taken .....	50
Number of abnormal x-rays .....	7
Total number of blood cholesterol drawn .....	47
Number of abnormal (over 220 mgm.%) .....	15
Total number of blood sugar drawn .....	80
Number of abnormal (130 mgm.% or above) .....	7
It turned out that the quantitative blood sugar tests were made on these 7 and the high figure was 140 mgm.%.	
Total number of hemoglobins and blood smears .....	77
One hemoglobin was excessively high being 18.0 Gm. Another man on Dicumarol registered an identical reading.	
Total number of abnormal smears .....	3

It has been the privilege of your chairman to serve as a member of the State-Wide Coordinating Council on Tuberculosis during the past year. In his capacity as chairman of the Committee on Tuberculosis and Public Health, he has represented the Florida Medical Association on the Coordinating Council. Members of the State-Wide Coordinating Council on Tuberculosis include:

- Samuel P. Martin, M.D., Chairman; Professor of Medicine, University of Florida College of Medicine.
- Kip G. Kelso, M.D., President, Florida Trudeau Society.
- Claud M. Andrews, State Director, Vocational Rehabilitation Service.
- Roberts Davies, M.D., Director, State Tuberculosis Board.
- Hawley H. Seiler, M.D., Chairman, FMA Committee on Tuberculosis and Public Health.
- Miss Ruth Mettinger, R.N., Director, Division of Public Health Nursing, Florida State Board of Health.
- M. Eugene Flipse, M.D., Department of Medicine University of Miami School of Medicine.
- C. M. Sharp, M.D., Director, Bureau of Preventable Diseases, Florida State Board of Health.
- Miss Sara MacNamara, President, Florida Conference of Tuberculosis Workers.
- Frank M. Craft, Acting State Director, Department of Public Welfare.
- James T. Vocelle, Director, Florida Industrial Commission.
- A. Y. Covington, M.D., President, Florida Health Officers' Conference.
- Thomas D. Bailey, Superintendent, State Department of Education.
- Ernest A. Lilley, President, Florida Tuberculosis and Health Association.
- W. E. Bird, President, State Association of County Commissioners.

The initial meeting of the Council was held Dec. 1, 1956, in Jacksonville. Subsequent meetings were held on Aug. 14, 1958, Dec. 15, 1958 and Feb. 23, 1959, all at the J. Hillis Miller Health Center of the University of Florida, in Gainesville. These sessions were devoted primarily to discussions of current problems in tuberculosis control in Florida as they affect the various agencies represented.

It was proposed that the F.M.A. Committee on Tuberculosis and Public Health plan for and sponsor pulmonary disease conferences for physicians at county or regional levels, with assistance from the two medical schools. This proposal was submitted to the various committee members and it was the unanimous opinion of your Committee that such conferences would be beneficial and should be encouraged. Accordingly, proper authorities at the two medical schools in the state were approached and the problem discussed. Plans are being formulated to have the first such conference at the University of Florida, College of Medicine, in Gainesville, within one year followed by a second conference at the University of Miami School of Medicine, in Miami. These conferences will be designed especially for the general practitioner, although all physicians will, of course, be welcome to attend.

The State-Wide Coordinating Council on Tuberculosis further suggested to the F.M.A. Committee on Tuberculosis and Public Health that a campaign be conducted to encourage physicians of the state to use the facilities of the various state tuberculosis hospitals for patients currently needing treatment, diagnostic work-up in suspected cases, physical and mental indoctrination, and so forth. Your Committee has been informed of the establishment of much needed outpatient clinics by the State Tuberculosis Board and staffed by members of the various tuberculosis hospitals. These clinics are designed essentially for follow-up care following hospital discharge, diagnostic and other aid, and are held primarily in rural centers where such assistance is most needed.

### Supplement 1

WHEREAS, The tuberculosis program of the FLORIDA STATE BOARD OF HEALTH and the STATE TUBERCULOSIS BOARD has proven to be highly effective in hastening the control of tuberculosis as a health menace in this state, and

WHEREAS, this program is being presently discredited by the release of a two-year old report of a Florida State Senate Investigating Committee, and

WHEREAS, destructive legislation based upon this report has been recommended in the current session of the Legislature, and

WHEREAS, the enactment of such adverse legislation would severely cripple continued progress in the control of tuberculosis in this state,

THEREFORE BE IT RESOLVED, That the FLORIDA MEDICAL ASSOCIATION go on record as endorsing the principles and policies of the STATE TUBERCULOSIS BOARD and the FLORIDA STATE BOARD OF HEALTH and.

BE IT FURTHER RESOLVED, That the FLORIDA MEDICAL ASSOCIATION expresses its disapproval of any legislation which would be detrimental to the health or civic liberties of the citizens of this state as it relates to the control of tuberculosis.

### Supplement 2

A bill has been introduced in the Florida Legislature to prohibit fluoridation of public water supplies. It is recommended that the Florida Medical Association oppose this bill in the interest of public health.

Dr. Maxwell: "The report of the Committee on Maternal Welfare as presented by Dr. E. Frank McCall, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Dobbins.

Motion carried.

## Report of Committee on Maternal Welfare

E. FRANK McCALL, *Chairman*

The Maternal Welfare Committee has had three planned meetings for discussion; one at the Florida Medical Association meeting, one at Atlanta where we met with representatives of Georgia, South Carolina, and Alabama, and one at Daytona Beach. The Maternal Welfare Committee, sponsored by the State Boards of Health of Florida, Georgia, South Carolina, and Alabama, held an Obstetric-Pediatric Seminar at Daytona Beach September 8, 9, and 10. The registration was 418, which is the largest meeting we have ever had. The faculty for this meeting was composed of outstanding professors in the field of obstetrics and pediatrics. A meeting was held February 26 with representatives of the Boards of Health of Florida, Georgia, South Carolina, and Alabama, at which time the tentative plans for the Obstetric-Pediatric Seminar were discussed.



The maternal mortality for the State of Florida for 1958, through November, was approximately 10 per 10,000 live births, an increase over 1957, which showed 6.1 per 10,000 with the national average being 6 per 10,000. There were sixty-two maternal deaths in 1958. Twenty four of these were white, or 3.9 per 10,000, and thirty eight were colored, or 10 per 10,000 live births. The birth rate for 1958, through November, was 97,823. The death rate among the whites is still far below the national average, and the colored is one and one-half times the national average, which is a considerable improvement over the 1957 colored mortality. Again this year, every effort will be directed toward some program for again reducing the colored maternal mortality.

We are deeply grateful for the help we have had from our sponsors in promoting this meeting. I would especially like to express our appreciation to the State Boards of Health in each participating state, and particularly to Doctors Sowder and Doff, and to Mrs. Cochley with the Florida State Board of Health.

Dr. Maxwell: "The report of the Committee on Child Health as presented by Warren W. Quillian, M.D., Chairman, is approved as printed in the Handbook. The Committee approves the first supplemental report with the exception of Section VI, which is disapproved. Supplemental report No. 2 dealing with the examination of school bus drivers is approved as is supplemental report No. 3 regarding tetanus toxoid immunization.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. W. Dean Steward.

Motion carried.

## Report of Committee on Child Health

WARREN W. QUILLIAN, *Chairman*

During the past year there has been a considerable increase in the scope and efficiency of this Committee. Fundamentally, our efforts consist of cooperation with and guidance for programs designed for the betterment of health in children from birth through the early school years. Members of the Committee have helped with the formation and administration of activities initiated by the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics for improvement of methods and standards for management of the newborn and premature. Plans have been made for an educational and service-training program in premature care among smaller communities of the state where formal demonstration centers are not readily available. This has become possible largely through the efforts of the combined interest of the Bureau of Maternal and Child Health of the State Board of Health and of the Florida Pediatric Society.

The Committee has recommended statewide distribution of safety precaution leaflets to all physicians in Florida, at the request of the Accident Prevention Committee of the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics.

The President and Board of Governors of the Florida Medical Association have designated our Committee as a School Health Medical Advisory Committee to the State Department of Education and the State Board of Health. A joint meeting was held at the F.M.A. building in Jacksonville on Nov. 29, 1958 to obtain information concerning the nature and activities of the school health

program in Florida. We are very proud of the accomplishments of the State Board of Health and the State Department of Education in the establishment of adequate standards and programs for the health of school children in Florida. Believing that the total school program is a community enterprise basically, this Committee has recommended to the Board of Governors of the F.M.A. that the county medical societies throughout the state designate local committees on school health to serve in an advisory capacity with the school administration, county superintendents, Board of Health and Parent-Teacher organizations in matters pertaining to school health. Many problems concerning safety education, nutrition, mental health, and family adjustments can best be solved at the local level. But proper solution demands the cooperative efforts of local health departments, voluntary health agencies, medicine, dentistry and many other allied groups.

Further meetings with the State Board of Health and the State Department of Education have been scheduled. The Child Health Committee believes this new function and relationship is an opportunity and challenge to Florida physicians to help constructively in community welfare.

The F.M.A. Committee on Conservation of Vision, through its Chairman, Dr. Marion W. Hester of Lakeland, has proposed a statewide program of medically supervised eye screening in all the schools of Florida. This includes the use of inexpensive, reasonably accurate, methods to detect defective visual acuity, excessive hyperopia and abnormal muscle balance. The Child Health Committee endorses eye screening tests as a part of the school health program, and recommends the approval of the proposals as outlined in the report of the Committee on Conservation of Vision (q.v.).

The Chairman of your Committee on Child Health was officially appointed to attend a regional conference on staphylococcal infections in Atlanta, Ga., on Oct. 6, 1958. Certain comments and recommendations were made to the F.M.A. Board of Governors following that conference. These are not properly a part of this report, but may be available to interested members of the Association through the report of the Board of Governors.

It is heartening to find a general interest in the problems of child health. This Committee is willing and anxious to furnish medical counsel and guidance when requested. Better medical care for more children in Florida involves constant revision and implementation of programs already begun. We wish to thank the members of the Florida Medical Association for their help in the interpretation to parents and other adults of the principles recommended in the proposals for improvement of child health in this state.

### Supplement 1

On March 14, 1959, the Committee on Child Health met with the representatives from the State Board of Health and the State Department of Education, at F.M.A. Headquarters in Jacksonville. Certain highlights of that meeting and recommendations which were made by the Committee are worthy of note.

Responsibility for health care in the schools is jointly shared by the Department of Education and the State Board of Health. Other agencies and interested groups may make recommendations to them.

Discussion emphasized the importance of school health committees at the county level in solving problems of primarily local interest. Some areas in our state have local school health councils of the school board and the Department of Public Health without adequate representation from the county medical and dental societies, who might serve in an advisory capacity.

### Recommendations:

**MEDICALLY TRAINED PERSONNEL IN SCHOOLS:** I. The Committee recommended that Medically Trained Personnel in the schools be obtained, their duties guided and supervised by the County Health Department.

**EXAMINATION FOR SCHOOL PERSONNEL: II.** Further recommendation was made that adequate evidence be submitted each year that every person employed by the schools is free from active Tuberculosis infection by procedures based upon standards acceptable to medical opinion in the local community.

**PHYSICAL EXAMINATION FOR STUDENTS: III.** Although it is felt to be desirable that a goal of four complete physical examinations be made during the career of school age children, the Committee recommends that at present, a minimum standard be attempted with two examinations, namely one prior to school entrance and one during the preadolescence period. This is a realistic and more practical approach to the problem.

**EDUCATIONAL PROGRAM: IV.** Recognizing the importance of parental understanding in the success of any program of school health, the Committee recommends that the State Department of Education and the State Board of Health, in cooperation with the local boards of public instruction, public health departments, and medical societies, exercise increased efforts toward informing the public concerning the aims and objectives of a good school health program.

**EYE SCREENING PROGRAM: V.** The Committee reaffirmed its approval in principle, of the recommendations of the Committee on Conservation of Vision with reference to the eye screening program as carried out in the public study in Polk County. It was further recommended that this program be implemented as widely as possible in the establishment of uniform standards throughout the state.

All of the above recommendations were formally approved by the Board of Governors at their meeting on March 22, 1959.

#### **Supplement 2 Resolution School Bus Drivers' Examinations**

Resolved that the present law whereby school bus drivers must be examined by from one to three physicians appointed by the County should be changed to allow the patient to select his own physician, rather than one appointed by any governmental agency.

Be it also resolved that inasmuch as the drivers must pay for this examination themselves, our Society feels that this system is unwieldy and unfair in that it abrogates the principles of free choice of physician for a patient who is paying his own way.

Furthermore, it is our suggestion that a standard criteria be arrived at which should be met by the drivers in order that they be certified.

Respectfully submitted,  
James C. Carver, M.D., Secretary  
Lee County Medical Society

#### **Supplement 3 Resolution Tetanus Toxoid Immunizations**

WHEREAS, Tetanus (Lockjaw) is a serious disease which continues to kill hundreds of people annually as a result of wounds of severe or minor nature, and

WHEREAS, Tetanus Toxoid has been proven to give excellent prophylactic results as exemplified by the fact that only 11 of 13,000,000 inoculated servicemen developed tetanus during World War II, and

WHEREAS, Tetanus antiserum not only gives poorer prophylactic protection than toxoid, but its administration is time-consuming and can be dangerous, and

WHEREAS, Florida soil continues to harbor tetanus bacilli which cause this dread disease, and

WHEREAS, A catastrophe might bring serious consequences to many citizens of our county from tetanus which could be prevented by advance planning and proper immunizations.

BE IT THEREFORE RESOLVED, That the Duval

County Medical Society urge the citizens of Duval County and the State of Florida to get proper tetanus toxoid, original and booster, from their physicians and immunizations as indicated, and

That public health officials, civil defense organizations and other interested groups study means of identifying persons who have been immunized and that they make recommendations regarding this phase of the problem, and that

Members of the Duval County Medical Society cooperate in the administration of toxoid as was done in the successful polio immunization program, and that

Public Health services, newspapers, television, radio and other public media be utilized to the fullest extent in advising our citizens of this critical need, and that

A copy of this resolution be sent to the Florida Medical Association and the American Medical Association with the recommendation that a resolution of similar nature be adopted by the House of Delegates of these organizations in order that the people of our state and nation may be told of this urgent problem.

This resolution is a true and a complete copy of the resolution passed by the Cabinet of the Duval County Medical Society in regular meeting assembled on April 30, 1959, at Jacksonville, Florida.

Respectfully submitted,  
Samuel M. Day, M.D., President  
Duval County Medical Society

Dr. Maxwell: "The report of the Committee on Cancer Control as presented by Dr. Robert F. Dickey, Chairman, is approved as printed in the Handbook. The Committee disapproves of the resolution submitted by the St. Lucie-Okeechobee-Martin County Medical Society, calling for the Florida Medical Association to urge state assistance to cancer patients under the Hospital Services for the Indigent Program without the prerequisite of tumor clinic approval.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Chas. J. Collins.

The Chair recognized Dr. Richard F. Sinnott to discuss the motion.

Dr. Sinnott: "In this matter there is some misunderstanding. We are not against the tumor clinics. Our resolution was aimed only against two principles which we believed were mistakenly adopted by this assembly last year. First we agreed in our action last year to channel these patients through the approved tumor clinics; we agreed that state assistance precludes free choice of physician. We are not blind to the political facts of life. We realize that the State Board of Health has close liaison with the Florida Medical Association, but do not believe that is necessarily a perpetual state of affairs. The State Board of Health may come under lay control, and it is possible that it might decide that patients could be treated only at Gainesville or only at Miami. Under the present system the patient does have free choice of physician. We are not against cancer clinics. We feel that if the cancer clinics



are doing an excellent job they will live on and on."

The Chair recognized Dr. Frederick H. Bowen.

Dr. Bowen: "I think we should remember in this problem that the tumor clinics serve a very great educational value and this is dependent on having a number of patients channeled through this particular facility. This educational value is important for the doctors who come to these clinics, see these patients and supervise their treatment. In the clinic at Duval Medical Center, we have trained about 15 doctors who are practicing in various parts of Florida; so the whole state benefits from this program. It is also of value to the patients to be channeled through these tumor clinics and be seen by doctors who are seeing a lot of cancer and who are expert in its treatment. In general, the tumor clinics are better equipped and better able to carry out the treatment of these patients. It has been pointed out that this may be a harmful trend if we follow this process of putting the patients through the tumor clinics. If it proves to be harmful, we can take the matter up again and reverse the trend without too much difficulty."

Motion carried.

## Report of Committee on Cancer Control

ROBERT F. DICKEY, *Chairman*

A joint meeting of the Cancer Control Committee of the Florida Medical Association and the Florida Cancer Council was held in West Palm Beach, November 14, 1958.

It was decided that:

1. The State Board of Health obtain a Director that would visit and coordinate the various Cancer Clinics over the State more fully than is now possible. It was also agreed to recommend a sum of \$50,000 to the Budget Committee of the State of Florida to finance this extended coverage. The Budget Committee has since recommended a sum of \$49,000.
2. It was decided that patients referred to any of the Cancer Clinics by physicians should have the treatment recommended by the Clinic and the physician should treat the patient or direct the clinic to treat the patient as the physician desires for the good of the patient.
3. It was recommended that a Cancer Clinic be held during the spring meeting of the Florida Medical Association for demonstration and help of any physician or Cancer Clinic personnel that should wish to observe or desire help in their own Clinics.

Dr. Maxwell: "Mr. President, I move the adoption of the entire report as amended."

Seconded by Dr. David R. Murphey Jr.

Motion carried.

## Report of Reference Committee No. 2

### Public Policy

Dr. Henry J. Babers Jr.: "Mr. President and Members of the House of Delegates: Your reference committee on Public Policy gave careful consideration to items referred to it and makes the following report:

"The report of the Committee on Conservation of Vision, by Dr. Marion W. Hester, Chairman, and the supplemental report, are accepted as written in the Handbook, with the following amendment—that No. 2 of the principles outlined should read, 'All parts of the school health program, including vision, should be the responsibility of the County Health Officer and administered by him with the supervision and advice of the local medical society.'

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Fred E. Brammer.

Motion carried.

## Report of Committee on Conservation of Vision

MARION W. HESTER, *Chairman*

The Committee has formulated plans to install a uniform, medically supervised program of eye screening in all the elementary schools of the state of Florida. A conference on this subject was held last July with the State Health Officer and a short time later another was held with the Director of Maternal and Child Health of the Florida State Board of Health. Those attending these conferences thought that plans for the program were both feasible and desirable. In September 1958 following these talks, the plan was put into full scale operation in Polk County. This was considered a pilot plan to serve as a pattern for statewide use beginning with the next school year.

The program in Polk County follows recommendations made by the Florida Society of Ophthalmology and Otolaryngology and recommendations adopted by the House of Delegates of the Florida Medical Association in 1958. It is carried out by the Polk County Health Department using two full time, paid technicians. These technicians were trained by your Committee and have worked under Committee supervision. During this school year and by the time the school year ends, they will have carried out eye screening on all elementary school children in Polk County. These children number approximately 24,000. The equipment used has been the Atlantic City

test and a modification of the Atlantic City test built to Committee specifications, which the Committee calls the "Florida Test." These tests are accurate, simple, rapid, portable and inexpensive. About \$4,000 is being spent on the program in Polk County this school year. This means a cost of about 20 cents per child tested.

The Committee was represented at a meeting of the Florida Medical Association Committee on Child Health in Jacksonville Nov. 29, 1958.

Committee members were lecturers at The Vision Workshop sponsored by the Florida State Department of Education, the Florida State Board of Health and the Florida Council for the Blind in Tallahassee Jan. 15-16, 1959.

The Committee Chairman was a lecturer on methods of eye screening at the Annual Conference of County Health Officers at the State Board of Health in Jacksonville Feb. 9-11, 1959.

The Committee feels that eye screening as done in schools should be governed by the following principles:

1. Eye screening is a part of the school health program and is therefore strictly in the field of medicine.
2. All parts of the school health program, including vision, should be the responsibility of the County Health Officer and administered by him with the supervision and advice of the local medical society.
3. Eye screening methods used in schools should be those approved by the Florida Society of Ophthalmology and Otolaryngology.
4. Eye screening in schools should be a means of detecting the need for referral to the eye specialist and should not be regarded as an eye examination.

### Supplement

The plans to install a uniform medically supervised program of eye screening in all the elementary schools of the State of Florida has been endorsed by the FMA Child Health Committee acting in its capacity as an advisory committee to the State Board of Education and the Florida State Board of Health.

Dr. Babers: "The report of the Committee on Medical Education and Hospitals, presented by Dr. Jack Q. Cleveland, Chairman, is endorsed and it is recommended that a contribution of \$7.50 per member per year be made and that the Florida Medical Foundation send a statement as of November 1, 1959 to each member.

"Mr. President, I move adoption of this portion of the report."

Motion duly seconded and carried.

### Report of Committee on Medical Education and Hospitals

JACK Q. CLEVELAND, *Chairman*

Your Chairman attended the annual State Chairmen's Meeting of the American Medical Education Foundation in Chicago January 24th and 25th.

The total amount contributed to the A.M.E.F. in 1958 from Florida was \$6,978 from 243 contributors. This amount is an increase over 1957 but Florida is still fifth in the South in amount contributed. The Woman's Auxiliary, always a potent force in our program, continues to put A.M.E.F. at the head of its large list of activities. Not only have we seen a rise in the group's contributions, but also, we suspect, their influence on their husbands is seen in larger physician contributions.

None of us need be reminded of the need for funds for medical education in our country. A.M.E.F. supplies help for the undergraduate teaching programs of the 85 approved medical schools in the U. S. Annual grants are made to the schools, who, themselves, determine where the money is most needed. Since its inception in 1952, the A.M.E.F. has contributed about one million dollars annually to the medical schools. Any contribution given to the A.M.E.F. may be ear-marked for one's Alma Mater or any school chosen.

Your committee for the A.M.E.F. would like to have a contribution (the amount is up to the donor) from every member of the Florida Medical Association. We could more than double our 1958 contribution if every member would give even \$5.00.

Once again, we would like to recommend to the House of Delegates that a voluntary contribution of \$7.50 per member, per year, be made to the Florida Medical Foundation for the American Medical Education Foundation.

Dr. Babers: "The report of the Sub-Committee on Medical Schools Liaison and supplement by Dr. Walter E. Murphree, Chairman, is approved and adoption recommended. The work of the committee is commended.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herz.

Motion carried.

### Report of Sub-Committee on Medical Schools Liaison

WALTER E. MURPHREE, *Chairman*

No problem has been referred to the Committee this year and therefore no Committee meeting has been held.

The University of Florida College of Medicine Teaching Hospital opened for patients on Oct. 20, 1958. Full capacity of this hospital is being slow to develop. At the present time only between 40 and 50 beds are being utilized. A problem of desirable income level of patients being admitted to the teaching hospital has arisen and is being given considerable attention by the local Alachua County Liaison Committee. It is hoped that this problem will be resolved locally, but it may well be that a meeting of this Committee will be called this spring, and if so, a supplemental report will be given at the House of Delegates meeting in May.

The subcommittee met at the F.M.A. office on March 1, 1959, to consider matters referred to it by President Annis. Specifically these matters were consideration of an income level for patients which would enable them to be admitted to the University of Florida Teaching Hospital for a hospital charge but no professional fee, and a \$150 "package deal" for obstetrical patients. Under the former an income level of from \$2,400 to \$6,000 had been set up, and it was quickly realized that this would cover a goodly proportion of the general population of the entire state. After considerable discussion of these matters the recommendation of the subcommittee was that:

1. For admission to the University of Florida Teaching Hospital, determination of indigency shall be made by the respective county agency responsible and that any patient not so certified shall be subject to the usual hospital charges and professional fees set by the physician.
2. The present tentative patient income classification schedule issued by the University of Florida College of Medicine be eliminated and that instead its Business Office furnish financial information



on individual patients to aid physicians in setting their fees.

3. For obstetrical patients at the University of Florida Teaching Hospital, the present "package deal" of \$150 for complete care be abolished and all non-indigent patients be subjected to the usual hospital charges and professional fees.
4. The resolution from the Dade County Medical Association urging that instruction in hypnotherapy be made available on a postgraduate level by the medical schools in Florida, be referred to the FMA Committee on Medical Postgraduate Course.

Dean Harrell of the University of Florida College of Medicine indicated that he would accept these recommendations and put them into effect immediately. Dean Marsh of the University of Miami School of Medicine indicated that these would not conflict with his policies.

A permanent item of the agenda for each of these committee meetings was to be a discussion of salaries earned by medical faculty. At the present time none of the faculty has been able to supplement his salary since the hospital has not been opened long enough to do so. This item remains on the permanent agenda.

Dr. Babers: "The report of the Committee on Medical Economics, by Dr. S. Carnes Harvard, Chairman, is endorsed as written in the Handbook. The supplemental report is endorsed enthusiastically and its adoption recommended.

"Mr. President, I move the adoption of this portion of the report."

Motion duly seconded and carried.

## Report of Committee on Medical Economics

S. CARNES HARVARD, *Chairman*

The Committee during the past year has been concerned primarily with expanding and improving the Association's insurance program. As was the case last year, the most important economic matters facing the Association are of such magnitude that they have been handled by separate committees on Medicare and Advisory to Blue Shield (Committee of 17).

On October 11, 1958 the Committee met in the F.M.A. Building, Jacksonville, to consider additions to the insurance program for presentation to the Board of Governors on the following day. The Board unanimously approved the following recommendations:

1. That the Trust Department of the Florida National Group of Banks be authorized to prepare a prospectus for an F.M.A. Group Investment Trust Plan in order to be able to take advantage of the Herlong-Jenkins-Keogh type legislation permitting tax deferred pension plans for professional people, when and if such legislation is enacted by the Congress. The Trust Plan is to include provisions for stock funds (equities), stock and bond funds (equity and dollar value), bond fund (dollar) and insurance. This authorization to the Florida National Group of Banks was with the understanding that there shall be no liability on the Association for its preparations and no commitment that it will be accepted.

Any progress on this plan and the status of such legislation in Congress will be presented later in a supplement to this report.

2. That the Committee on Medical Economics cooperate with the Committee on Legislation to endeavor to amend the Florida Statutes to permit true group insurance for professional associations. In connection with this proposed legislation the Board approved:

- (a) That the desired legislation be drafted similar to the Ohio Statutes to include members of the medical, dental, accounting, and legal professions.
- (b) That this legislation be permissive but not mandatory for the inclusion of employees of members of these professional groups.
- (c) That this legislation be all inclusive in one bill if possible, amending the various sections of the Statutes as required.
- (d) That, after such proposed legislation has been prepared, it shall be presented to the other participating professional associations, requesting their assistance in attempting to obtain passage of the legislation, and that they inform their legislators in this regard prior to the 1959 Session.
- (e) That after preliminary work has been completed and the various associations have agreed on the proposal, then contact shall be made with the home offices of larger insurance corporations requesting their support.

An inter-professional meeting, sponsored by F.M.A., was held in Jacksonville on January 18. Present were representatives from the Florida Association of Architects, The Florida Bar, Florida Engineering Society, Florida Institute of Certified Public Accountants, Florida State Dental Society, Florida Nurses Association, Florida State Board of Nursing, and the Florida Medical Association. It was agreed that the Florida State Pharmaceutical Association and the Florida State Veterinary Medical Association be invited to participate. The group was in agreement with the proposal to seek this type of legislation and agreed to work toward its accomplishment.

3. That office overhead expense protection, which is available through Marsh & McLennan, the Association's insurance administrators, and underwritten by the Continental Casualty Company be made available to members who may wish this type of protection.

This insurance is now available provided at least 100 members participate but the Committee wishes to call to the attention of interested members that although the premium on this type of insurance is tax-deductible, as a business expense, any benefits must be reported as income.

4. That accident insurance and total disability protection be made available to the membership with the endorsement of the Association. This insurance is now available through Marsh & McLennan, underwritten by the Columbia Casualty Company at extremely low rates provided at least 100 members participate.

At this writing, approximately six weeks after this accident insurance and the office overhead protection were first made available to the membership, the required participation has not been obtained for either plan. It seems almost unbelievable that out of a membership of some 3,600 fewer than 100 would be interested.

5. That every effort be made to stimulate interest and participation in the disability income protection plan.

During the first two years this plan has been in operation there has been good premium experience and if it continues, Continental Casualty will be requested by Marsh & McLennan to reduce the premium or increase the benefits. If this occurs we will then be in a position for an all-out campaign to reach the required minimum of 50 per cent which is necessary before members who are uninsurable on an individual basis may be able to

get this type of coverage. At the request of the Association the Woman's Auxiliary has taken as one of its projects an attempt to make certain that every member knows that disability income protection is available through the Association's Plan.

I should like to urge every member who is not already participating in this program to take a good look at the benefits offered at the premiums charged. If you do not wish to change insurance carriers, it may be well worth your while to take an inventory to see whether you do not need some additional protection through the F.M.A. program. You will be doing yourself a great favor as well as those members who are now unable to get this type of insurance. If 50 per cent of the eligible members are participating in the program, any F.M.A. member without regard to medical history can obtain disability income protection, subject to reduced amount and period of disability indemnity. If at least 60 per cent participate, applicants with adverse medical history are subject only to reduced amounts of indemnity, not a reduced period.

6. That travel accident insurance be purchased by the Association to cover travel on Association business by officers, members of the Board of Governors, committee members, delegates and executive office staff. This has been put into effect.

The Committee is continuing its attempt to obtain an insurance carrier which will be willing to underwrite the professional liability program for members. We have investigated numerous leads but none has as yet been found which is considered acceptable. We are also following closely some new experiments in this field in other parts of the country. Marsh & McLennan has worked on this most arduously and is continuing to attempt to find a solution. In the meantime the Committee will continue its educational program through the county medical societies.

Your committee urgently requests any F.M.A. member who is having problems relating to insurance to bring them to the attention of the Committee on Medical Economics and to call upon it for assistance rather than going directly to the Insurance Commissioner.

### Supplement

Your Committee recommends the establishment of an investment plan for members of the Association to be known as the FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST. This Trust is to be established in principle with two divisions as follows:

#### FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST

##### DIVISION I

A. RESTRICTED RETIREMENT TRUST drawn to meet the requirements of the Keogh Bill, H.R. 10, as well as Treasury regulations to qualify for self-employed tax deferment, to offer for selection by participants a diversification of portfolios such as:

1. Equity Fund (Common Stocks)
2. Dollar Fund (Bonds - Mortgages)
3. Insurance program
4. a. Insurance and Equity Fund
- b. Insurance and Dollar Fund
- c. Equity and Dollar
- d. Equity, Dollar and Insurance

##### DIVISION II

A. INVESTMENT FUND open for members to which contributions could be made in amounts with minimum contributions in multiples of \$50.00 with 1,000 as a minimum number of participants in order to obtain diversification in portfolios for selection by participants such as:

1. Equity Fund
2. Dollar Fund
3. Equity and Dollar Fund

Division II would offer no tax deferment.

Both of these plans would be under the jurisdiction of the Board of Governors, or the Association's designated Florida Medical Association Investment Trust Committee, of the Florida Medical Association in such matters as policy, interpretation and investments.

Functions of the Trustee under the plan are to:

1. Receive funds from participating members.
2. Disburse funds in accordance with plan.
3. Invest, re-invest, sell, exchange and perform all acts necessary to maintain the trust portfolio in accordance with the directions of the Board of Governors, or the Association's designated Florida Medical Association Investment Trust Committee, and in compliance with regulations—Keogh and Treasury.
4. Collect all income and proceeds from investments as they become due and make appropriate credits.
5. Consult with and advise, when necessary, the Board of Governors regarding changes of ratings and other data pertinent to the portfolio of the trust. (Information from various Services)
6. Furnish statements of account at periods requested by Board of Governors.
7. Allocation of funds contributed by participants together with statement of respective unit holdings in portfolio.
8. Valuation of portfolio, probably on a quarterly basis, with allocation of income, appreciation or depreciation, through comingling of funds to arrive at unit valuation.

Functions of the Board of Governors, or the Association's designated Florida Medical Association Investment Trust Committee are to:

1. Advise trustee as to eligible members.
2. Consult with and maybe direct investments.
3. Secure bids and select insurance underwriters and agents for insurance requirements under the plan.
4. Review investment portfolio.
5. Interpret plan.
6. Set policy.

Dr. Babers: "The report of the Committee on Representatives to Industrial Council is approved. 1. The work of this Committee is highly commended. 2. The supplementary average fee schedule, which does not appear in the Handbook, is accepted. 3. It is understood that this fee schedule must be negotiated. 4. We recommend strongly that this Committee, headed by Dr. P. G. Batson Jr., be given authority to represent this Association and negotiate a fee schedule for the Association using its 'proposed revision of the average fee schedule' as a basis.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

## Report of Representatives to Industrial Council

P. G. BATSON JR., *Chairman*

The Committee met in the F.M.A. Building, Jacksonville, on Dec. 13, 1958 for the primary purpose of final consideration of a proposed revision to the Workmen's Compensation Average Fee Schedule for submission to the Florida Industrial Commission.

Members of the Committee present were Drs. Batson, Ryon, and Killinger. Others present were Drs. John H. Mitchell, Lloyd J. Netto, Richard A. Nelson, Mr. Ernest Gibson, Mr. Alvin D. James and Miss June Palmer, Recorder.



The decisions of the Committee were:

1. To accept the Blue Shield schedule of benefits as originally proposed to the House of Delegates in May 1958 (\$6,000 income level), with the following changes:
  - (a) Initial office visit and report ..... \$ 10.00
  - (b) Hospital emergency room call  
and treatment ..... 10.00
  - (c) Subsequent office visits ..... 5.00
  - (d) All injections (additional for  
expensive drugs) ..... 3.00
  - (e) Assistants' fee \$25.00 per hour,  
maximum \$50.00
  - (f) Allowance for office visit plus physical  
therapy treatment when time was actu-  
ally given by physician and physical  
therapist
  - (g) Hernia fee reduced to ..... 150.00  
Bilateral ..... 200.00
2. To await reaction of the Insurance Commissioner to the new Blue Shield contract.
3. To prepare a schedule of benefits to present to the Industrial Commission which would show:
  - (a) Nomenclature as in Blue Shield schedule
  - (b) The relative value units
  - (c) The fee in dollars and cents based on the con-  
version factors of 5 for surgery and 6 for medical
4. To request the authorization of legal counsel to:
  - (a) Interpret sections of the Workmen's Compensa-  
tion Act
  - (b) Represent the Committee at the hearing before the  
Industrial Commission

The Committee expressed a preference for utilization of the Association's attorney as legal counsel and instructed the Executive Director to make the necessary arrangements.

The subsequent letter from Attorney Harry T. Gray of Marks, Gray, Yates, Conroy & Gibbs, Jacksonville, indicated that he would be available to represent the Florida Medical Association and its representatives at the hearing before the Industrial Commission. It is anticipated that the Florida Medical Association members who know various members of the Industrial Commission will be able to make a personal contact with them in regard to this matter before or during the time of the hearing.

### Supplement

This is to report the current status of the activities of the Committee on Representatives to Industrial Council.

During the past months the Committee has worked diligently in preparing a proposed revision of the fee schedules for medical, surgical, radiological and related professional services in the implementation of The Florida Workmen's Compensation Act. A final draft of the proposed fee schedule has been forwarded to the Association's attorney with the request that a petition be directed to the Industrial Commission requesting a hearing. It is expected that the preliminary hearing date will be set during the month of May.

Dr. Babers: "The report of the Grievance Committee as presented by Dr. Frederick K. Herpel, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herbert E. White.

Motion carried.

### Report of Grievance Committee

FREDERICK K. HERPEL, *Chairman*

The activities of the Grievance Committee of the Florida Medical Association during the year 1958-1959

have been significantly diminished as a result of the action taken by the House of Delegates at its last meeting in 1958. This authorized direct reference of complaints and grievances, received at the offices of the Florida Medical Association, to the chairman of the local county medical society grievance committee, rather than through the Chairman of the Grievance Committee of the Florida Medical Association. This has markedly decreased the amount of correspondence by the Chairman of the State Grievance Committee.

Throughout the year it has been the experience of the State Committee that the local county medical society grievance committees have functioned adequately. Their response to references has been prompt and I believe their settlements and recommendations have been generally accepted by both complainant and physician. This comment is made with the full realization that there are many complaints and grievances which are handled satisfactorily by the local county grievance committees without ever coming to the attention of the State Grievance Committee. Only one direct appeal has been made to the State Grievance Committee and in this instance the State Grievance Committee felt justified in upholding the decision of the local county committee.

Each year finds the grievance committees operating more efficiently in most county medical society organizations. Perhaps this is only due to the fact that county medical society organization as a whole is increasing in its complexity and at the same time operating more efficiently than it did in the past. The operation of grievance committees by the local medical society units is only one part of the organizational activities of these societies, but it seems to have taken its place definitely as a part of the county medical society responsibility.

After five years on the State Grievance Committee the Chairman is pleased to retire from this office and wishes to the succeeding Chairman and those following him every success in carrying out the directives of the Florida Medical Association and its House of Delegates in connection with grievances against physicians. An inescapable conclusion is reached as a result of watching the operations of this committee over a period of five years, and this conclusion is that the number of complaints and grievances between physician and patient are extremely few in number compared with the tremendous number of professional-patient contacts and the volume of medical and surgical services rendered to patients throughout the year.

This Committee has had no formal meeting together during the present year. The report is therefore that of the Chairman of the Grievance Committee of the Florida Medical Association, in which I trust the remaining members of the Committee will agree in substance.

Dr. Babers: "The report of the Committee on Nursing, headed by Dr. Thomas C. Kenaston, and the supplemental report are recommended. We commend them on their work and recommend every effort be made to help them salvage the Practical Nurse Training Program.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

### Report of Committee on Nursing

THOMAS C. KENASTON, *Chairman*

Your Committee has maintained a close liaison with the various nursing groups. There has been complete co-operation and no problems have arisen. Two members of your Committee have continued to serve on the State Advisory Committee for Practical Nursing Education. This latter committee is advisory to the Department of Education of the State of Florida.

The trend in nursing education coupled with the ever present shortage of nursing personnel gives us reason

for concern. It is obvious that this trend is away from the hospital diploma school and toward a collegiate program of nursing. The increasing requirements for accreditation are making it impossible for the hospitals to meet the unnecessary requirements imposed upon them. The result is the discontinuance of more and more hospital schools of nursing. In 1930 there were 1802 hospital schools and in 1958 there were only 768 such schools remaining on the national full and provisional accredited lists. Certain it is that the patient care as given by the hospital schools' "trained" nurse is equal to and at times superior to that supplied by her college-prepared colleague.

In the supplemental report of this Committee last year it was noted that the American Registry of Doctor's Nurses had temporarily suspended their activities in the State of Florida due to the fact that the Attorney General had ruled that they were operating illegally under the Nursing Practice Act of the State of Florida. We have recently been advised that this organization with Ralph Z. Bell as President is again operating by mail in this state but their headquarters are now in Washington, D. C. instead of Marianna, Florida. They allegedly have made certain technical changes so that they assert that they are no longer operating illegally.

### Supplement

The Interim Committee on Education of the State Legislature has recommended the abolition of state funds for Adult Vocational Education and placing the cost of operating such courses on the students through a tuition charge. This recommendation, if adopted by the Legislature, would handicap and possibly eliminate the Practical Nurse Training Program. For the most part the men and women enrolling in Practical Nursing classes are in the lower percentile income group and simply could not afford a high tuition fee in addition to the cost of uniforms, textbooks, and instructional supplies which they are already paying for.

Eleven counties are conducting one year preparatory courses: Alachua, Bay, Dade, Duval, Escambia, Hillsborough, Leon, Pinellas, Polk, Sarasota and Volusia. Over 1,500 practical nurses have graduated from these courses.

Discontinuation of the state appropriation for this purpose would also result in the loss of the Federal appropriation which has amounted to nearly \$60,000.00.

The Florida Medical Association, through its office in Tallahassee, has joined with the Department of Education to try to correct the possible tragic loss of the Practical Nurse Program. Further action, particularly from the counties now conducting the Practical Nurse Program and those counties that are planning to start such a program, could be of valuable aid in keeping the program going and in providing nursing personnel to make up for the ever increasing shortage.

Dr. Babers: "The report of the Committee on Blood, as presented by Dr. James N. Patterson, Chairman, is accepted as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. David R. Murphey Jr.

Motion carried.

### Report of Committee on Blood

JAMES N. PATTERSON, *Chairman*

The Committee on Blood has had no problem presented to it to date; so there has been no formal meeting.

The Joint Blood Council composed of two members from each of the following organizations: the American Medical Association, the American Hospital Association, the American Society of Clinical Pathologists, the Ameri-

can Association of Blood Banks and the American National Red Cross, is making progress in assuming its expected leadership in blood banking in this country.

The recent decision of the largest of the blood banks of the American National Red Cross to assess a penalty fee of \$25 for blood not replaced by a recipient, his family or friends, is hailed by all who believe in the free enterprise system. The Florida and the American Association of Blood Banks have from their beginning taken the stand that there is no such thing as "free" blood and that the responsibility for replacement should be that of the patient and not of the community. In this manner only can an adequate supply of blood be maintained. At long last, and no doubt reluctantly, the American Red Cross seems to have come to the same conclusion.

Dr. Babers: "The resolution of the Suwannee-Hamilton-Lafayette County Medical Society regarding a Liaison Committee with the State Board of Health is accepted in principle. However, this Committee recommends that a subcommittee of the present Tuberculosis and Public Health Committee be established to accomplish the functions outlined in this resolution.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Russell B. Carson.

Motion carried.

### Resolution

#### Liaison Committee with State Board of Health

RESOLVED, That the Florida Medical Association, by the appointment of a new liaison committee, seek to accomplish the following during the coming year:

1. Have the committee meet with Dr. Sowder or his representatives every four months and mail a report to the secretary and president of each county medical society, asking for suggestions and criticisms.

2. Urge the abolition of potentially dangerous injections by County Health nurses unless a physician is present, particularly desensitization injections and penicillin which are liable to cause anaphylactic shock and death unless promptly treated.

3. Establish a code of ethics for County Health physicians and nurses. This shall in no manner be discriminatory, but should be comparable with the ethics of physicians in private practice.

4. Attempt to encourage more centralized control over County Health units in regard to duties, particularly the treatment of patients by nurses. Also to urge the State Board of Health to clearly delineate the duties of County Health physicians and nurses.

5. Promote better harmony between members of Florida Medical Association in private practice and Florida State Board of Health by acting as a liaison committee for the discussion of any grievances or disagreements which arise, between the members of these bodies.

6. Submit a report at the next annual meeting of the Florida Medical Association on the progress made by the committee, and determine at that time whether the work has been worthwhile and a definite improvement made over the work now being done in this field.

Respectfully submitted,  
Frederick T. Mickler Jr., Secretary  
Suwannee-Hamilton-Lafayette  
County Medical Society

Dr. Babers: "The resolution in regard to Standardized Insurance Claim Forms submitted by the Broward County Medical Association has



been referred to the Sub-Committee to the Board of Governors on Commercial Health Insurance, Dr. Duncan T. McEwan, Chairman.

"Mr. President, I move adoption of this portion of the report."

Motion seconded and carried.

## Resolution

### Standardized Insurance Claim Forms

WHEREAS, More and more of our patients are covered by health and hospital insurance programs, and  
WHEREAS, Many of these said health and hospital insurers have lengthy and discursive claim forms to be filed, and

WHEREAS, We are, therefore, obligated to earnestly and honestly expend our time and efforts to file said claim forms with these insurers,

NOW THEREFORE BE IT RESOLVED, That a standardized and simplified claim form be prepared to cover the necessary pertinent information and that this standardized simplified claim form shall be adopted by the Florida Medical Association to be used throughout the State of Florida for the filing of said insurance claims.

Respectfully submitted,  
Miles J. Bielek, President  
Broward County Medical Association

Dr. Babers: "It is recommended that the resolutions from the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society and from the Broward County Medical Association concerning insurance examination fees be referred to the Sub-Committee to the Board of Governors on Commercial Health Insurance, Dr. Duncan T. McEwan, Chairman. The reason for this action is that there are numerous problems that should be evaluated and correlated before any action is taken.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

## Resolution

### Standard Life Insurance Examination Fees

WHEREAS, Physicians fees for standard life insurance examinations have remained static at \$7.50 for about ten years; and

WHEREAS, In this ten year period monetary inflation has required significant raises in salaries and other overhead expenses of physicians as well as life insurance companies; and

WHEREAS, This increase in salaries, etc., has been met by both physicians and life insurance companies except for a comparable adjustment of physicians' fees for standard insurance examinations; and

WHEREAS, Correspondence regarding this matter has been carried on with all insurance companies doing business locally for a period of six to nine months; and

WHEREAS, Insurance companies have shown no disposition to understand our problem or to voluntarily raise fees in the foreseeable future; and

WHEREAS, The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society of Florida voted unanimously with no dissenting vote to protect our interest by setting our fee at \$10, which is thought to be reasonable: Therefore be it

RESOLVED, That this Society go on record as recommending that our delegates to the State Medical Association present this resolution to that body and (b) that the local Life Underwriters Association be sent a copy and (c) that a copy of this resolution immediately be put in the hands of the Secretary of every County Association in the State of Florida and (d) that the State Association take steps and negotiate with life insurance companies in order to obtain a uniform rate throughout the State.

Respectfully submitted,  
Nelson H. Kraeft, Secretary  
Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

## Resolution

### Insurance Examination Fees

WHEREAS, the present fee for life insurance company physical examinations was set at the level of \$7.50 many years ago, and

WHEREAS, all facets of the cost of living index have risen in all areas, including life insurance premiums,

NOW THEREFORE BE IT RESOLVED, that this present fee of \$7.50 be changed and increased to \$10.00 for said physical examinations required by life insurance companies as requested in conjunction with applications for prospective insurance coverage.

Respectfully submitted,  
Miles J. Bielek, President  
Broward County Medical Association

Dr. Babers: "The resolution on Hospital Accreditation submitted by the Dade County Medical Association is endorsed as written and adopted unanimously.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Chas. J. Collins.

Motion carried.

## Resolution

### Hospital Accreditation

WHEREAS, The Joint Commission on Accreditation has been a noteworthy force in improving hospital patient care, and

WHEREAS, Organized medicine recognizes this fact and wishes to continue to benefit from the experiences of the Joint Commission on Accreditation, and

WHEREAS, There is much dissension amongst organized medicine concerning the methodology of the Joint Commission on Accreditation,

BE IT THEREFORE RESOLVED, That the Joint Commission on Accreditation be instructed to review its activities with a view to improvement in its practices relative to:

- (a) Recognizing community variations in hospital responsibilities and activities.
- (b) Reducing the onerous tasks placed on physician members of hospital staffs and making a concerted effort to reduce physician time spent in a multiplicity of technicalities and meetings.
- (c) Establishing a consistency of standards in each hospital from inspection to inspection.
- (d) Making the task of inspection attractive enough that all inspections are done by practicing physicians of caliber worthy of the task.
- (e) Recognizing their responsibility to organized medicine as a constructive force and refraining from arbitrary punitive decisions.
- (f) Recognizing the desirability of its accreditation and re-vamping procedures to make such accreditation obtainable at a reasonable time.

BE IT ALSO RESOLVED, That the Dade County Medical Association through its delegates to the Florida Medical Association request immediate action of the American Medical Association on the above.

Respectfully submitted,  
DeWitt C. Daughtry, Secretary  
Dade County Medical Association

Dr. Babers: "Mr. President, I move the adoption of this report as a whole."

Seconded by Dr. Herbert E. White.

Dr. Samuel M. Day: "I would like to bring up one point for reconsideration. That portion of the report of the Committee on Medical Education and Hospitals dealing with contributions to the American Medical Education Foundation states that a contribution of \$7.50 per year per member be made. Because we have a Florida Medical Foundation, I would like to see these funds channeled through that organization. I move for reconsideration of this portion of the report and to amend the report so that this \$7.50 would be sent to the American Medical Education Foundation through the Florida Medical Foundation. The Foundation is now tax-exempt; so it will accomplish the same thing, but will give credit to the Florida Medical Foundation."

Dr. Annis: "Let me clarify; the motion to adopt this report as a whole has been amended to change the wording so that, briefly, these funds would be channeled through the Florida Medical Foundation."

Seconded by Dr. Cecil M. Peek.

Dr. Evans: "Another question has been raised as to the wording, 'voluntary assessment.'"

Dr. Babers: "The Committee said 'contribution.'"

Dr. Cleveland: "I am sorry that the word 'assessment' got into my report. I did not mean

it that way. It should read 'voluntary contribution,' and I am sure the Committee on Medical Education and Hospitals has no objection to channeling this through the Foundation. The Committee believes that this will just be a reminder to the members; you can still earmark these funds for your own medical school. I think this step is quite important to counteract some of the propaganda that is rampant over the country that we are trying to cut down medical education because we don't want too much competition. The Committee has no objection to it going through the Florida Medical Foundation as long as it goes to medical education."

Dr. Carson: "Mr. President, I rise to a point of confusion. I believe we have before us the question of acceptance of the report as a whole and we are amending the acceptance of the report as a whole. I think it would be less confusing if we delayed the acceptance of the report as a whole and went back and put into Jack Cleveland's report what we want."

Dr. Annis: "We have a motion on the floor. The parliamentarian has advised me that we are still in good order. If we want to do what Dr. Day has suggested, all we have to do is to amend the motion and pass it. We will vote on the amendment."

Amendment carried.

Dr. Annis: "We will now vote on the amended motion of Dr. Babers' to accept the report as a whole."

Motion carried.

Dr. Annis: "Before we have the next report, let me announce that at this point we have one more doctor registered than ever before, 1,189. Our previous high was two years ago, 1,188."

## Report of Reference Committee No. 3

### Finance and Administration

Dr. White: "Your Reference Committee on Finance and Administration gave careful consideration to the items referred to it and makes the following report:

"Our President's fine and moving address is approved and his sentiments are strongly endorsed by our Committee.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Carson.

Motion carried.

(Complete text of the Presidential Address on page 21)

Dr. White: "The report of the Board of Governors and its supplement are approved with the following changes:

"1. The second paragraph of the report printed in the Handbook, in which Dr. Annis, extends his gratitude to Board Mem-



bers who have attended meetings at their own expense and at great sacrifice of time and convenience, is noted. It is recommended that in future expenses of attending Board meetings, other than the annual meeting, be reimbursed to Board members by the Florida Medical Association.

"2. On page 3 of the supplemental report, Item 8 (a) of the Statement of Principles with regard to members engaging in contract medicine shall be changed to read:

"8. This shall not be construed as denying any member of the Florida Medical Association the right to provide medical service to those who make no direct or indirect payment for such service while the physician acts as an agent or employee of:

a. A charitable, voluntary, health organization.

"On page 4 of the supplemental report, the paragraph titled 'KEY CONTACT PHYSICIANS' should be deleted, as we have been informed that the American Medical Association's Council on Legislative Activities has already sent a letter to each state medical society strongly urging them to consider the possibility of having an annual conference in Washington of their physicians and legislators and the Committee feels further action is unnecessary.

"Mr. President, I move the adoption of this portion of the report, as amended."

Seconded by Dr. Collins.

Motion carried.

## Report of Board of Governors

JERE W. ANNIS, *Chairman*

During the administrative year and prior to the printing of this report, three meetings of the Board have been held. These were at Bal Harbour, May 14, 1958, Jacksonville, October 11-12, 1958 and Jacksonville, January 11, 1959. Another meeting is scheduled for March 22, 1959. This will be covered in a supplement to this report and presented to the first meeting of the House of Delegates on May 3, 1959.

My deepest gratitude is extended to the members of the Board who have attended meetings at their own expense and at great sacrifice of time and convenience. I am certain that each member of the Association joins me in tendering them our sincere appreciation for their generous contribution. It is recommended that in future, expenses of attending Board meetings other than the annual meeting be reimbursed to Board members by the Florida Medical Association.

## Significant Changes

**DISCONTINUANCE OF DISTRICT MEETINGS.**—In accordance with the action of this House in 1958 the policy of holding district meetings in four sections of the state in the fall of the year was discontinued. In its place was

substituted a conference of the presidents and secretaries of county medical societies. This was held in Sellers Auditorium, Jacksonville, headquarters of the Duval County Medical Society, on December 14, 1958. Reports from the county society officers in attendance indicate that this is a highly desirable replacement for the medical district meetings. At this meeting a handbook for county society officers which had been prepared in the executive office was distributed. A model constitution and by-laws has also been prepared for use by county societies but because it is based on the proposed revision of the Association's charter and by-laws, it will not be available until after this meeting of the House of Delegates.

**REORGANIZATION OF EXECUTIVE OFFICE.**—In the interests of progress and effectiveness, the Board considered it advisable to rearrange the office eliminating the position of Managing Director and creating in its stead the position of Executive Director, to which Mr. W. Harold Parham has been appointed, with full responsibility for carrying out the directives of the Board. In accordance with the recommendations of the new executive director, a legislative department was added to the executive office with Mr. Alvin D. James as the director. Other changes brought about by the reorganization were the elevation of Mr. Eugene L. Nixon to director of the public relations department and Mr. Thomas R. Jarvis to the post of director of the publications department and managing editor of *The Journal*. Mrs. Zoe Pack remains in her capacity as director of the administration department.

**REORGANIZATION OF THE JOURNAL.**—In accordance with an action by this House of Delegates last year, a proposed constitutional amendment which would place the supervision and management of *The Journal* under the Board of Governors was submitted to the several county medical societies for ratification. At this writing fewer than fifty per cent of the county societies have reported their action on this constitutional revision. An additional report on this will be contained in the supplement.

## Major Activities

**ANNUAL MEETING.**—The Board approved the schedule and program for the annual meeting submitted by Dr. Lawrence E. Geeslin, Chairman, Scientific Work Committee, which is essentially the same as last year with the elimination of the annual banquet.

At the annual meeting at the Americana last year, there was dissatisfaction among the exhibitors because of low physician visitation to the exhibit hall and booths. This was brought about by a number of factors, the chief of which was the isolated location of the exhibit hall, the fact that there were no meetings scheduled in the immediate area and the extreme difficulty in reaching the hall from the lobby. At the Board meeting held at the close of the convention, the representative of the Medical Exhibitors Association, Mr. T. Frank Brown, appeared to explain the feelings of the technical exhibitors and to offer constructive criticism. Pursuant to this your President and representatives of the executive office worked with the officers of the Medical Exhibitors Association and the management of the hotel and developed a plan which we believe will be conducive to greater visitations in the exhibit area. Through the cooperation of the hotel, we have been able to put into effect virtually all of the recommendations of the officers of the Medical Exhibitors Association. We hope they will prove effective.

Let me urge upon each and every one of you to make it a point to visit the exhibits not once but several times during the meeting. You will find that they are a worthwhile part of our meeting, and most instructive and informative. It is also a gracious way of saying thanks to these firms who contribute to the success of our convention.

**BUDGET.**—The Board reviewed a financial statement and analysis for the business year ending December 31, 1958 and approved a proposed budget prepared by the Secretary-Treasurer and Executive Director in the amount



of \$215,000 for the calendar year 1959. This budget is based upon an estimated income of \$230,000 for the same period.

**PURCHASE OF PROPERTY.**—The Board authorized the purchase of property located at 739 Standish Place immediately adjoining the rear of the Association's present property and extending to the St. Johns River, at a price up to \$37,500, and authorized the Association's officers to borrow money for this purpose if necessary.

**TRAVEL ACCIDENT PLAN.**—Business travel accident insurance coverage was obtained by the Association for FMA officers, members of the Board of Governors, committees, delegates and staff for the protection of the individuals covered while traveling to conduct business of the Association.

**INDEXING OF VITAL RECORDS.**—Because it is no longer possible to keep in mind all the policies and directives of the House of Delegates and Board of Governors, and because the records have become too voluminous to permit location of information with ease, it was deemed advisable to compile and index all the proceedings of the House of Delegates and the minutes of the Board of Governors and for the same reason to duplicate this procedure for all the Florida Statutes applicable to the medical profession. To accomplish this two University of Florida students were employed during the summer. Both these young men did a fine job. The results of their labors are on file in the executive office. Already they have proven to be extremely beneficial.

**BLUE SHIELD RESEARCH ANALYST.**—In view of the extensive expansion in voluntary health insurance and in the light of the outstanding contribution by the Committee of 17, the Board recommended to the Blue Shield Board of Directors last fall that they seriously consider the employment of an independent research analyst for continuous and exhaustive study of Blue Shield's numerous problems.

**KEY CONTACT PHYSICIANS.**—Upon the recommendation of the F.M.A. Committee on Legislation and Public Policy, key contact physicians were appointed again this year for each U. S. Senator and Representative from Florida.

**SUB-COMMITTEE ON COMMERCIAL HEALTH INSURANCE.**—In view of the substantial part commercial carriers play in the provision of voluntary health insurance, it was deemed advisable to establish a sub-committee to the Board of Governors on commercial health insurance, such committee to work with representatives of the insurance industry to discuss mutual problems and to endeavor to solve them to the benefit of the subscribers, the insurance people and the medical profession. Past President Dr. Duncan T. McEwan of Orlando is the chairman of this sub-committee.

**LISTING OF HOSPITALS.**—The Board established the following policy for listing of hospitals by the Florida Medical Association:

- "1. Those hospitals currently listed by the State Board of Health (which is the official licensing agency for hospitals under the Florida law) and whose medical staff consists only of doctors of medicine.
2. That there be an indication by symbols as to whether the hospital is:
  - a. Licensed (by State Board of Health)
  - b. License pending (by State Board of Health)
  - c. Approved by the Joint Commission on the Accreditation of Hospitals
  - d. A member of the Florida Hospital Association
  - e. Approved for internship by the AMA
  - f. Approved for residencies or fellowships by the AMA
  - g. Approved schools of nursing (approved by the Florida State Board of Nursing)
3. That the listing state the following information regarding the hospitals:
  - a. Type
  - b. Owner
  - c. Number of beds and bassinets
 (This information to be obtained from the State Licensing Agency)"

**FLORIDA ASSOCIATION OF GENERAL SURGEONS AND FLORIDA NEUROSURGICAL SOCIETY.**—At the request of the officers of these recently organized societies, the Board approved these organizations as specialty groups recognized by the Association.

**PRESIDENT-ELECT OF AMERICAN MEDICAL ASSOCIATION.**—The Board continued its enthusiastic support, endorsed by the House of Delegates, of the candidacy of Dr. Louis M. Orr of Orlando for president-elect of the American Medical Association. You know that the campaign was successful and in a very few weeks Dr. Orr will be installed as the president of AMA.

### Assistance to Committees

During the year the Board has had opportunity and the privilege to work closely with many important committees of the Association. Included among the committees whose chairmen have appeared before the Board requesting assistance or presenting recommendations are the Committee on Aging, the Committee on Legislation and Public Policy, Advisory Committee to Blue Shield, Committee on Medical Economics, Representatives to Industrial Council and Medicare.

It is pertinent here to make a few comments with regard to Medicare. You are all aware that the Office of Dependents Medical Care instituted drastic changes effective October 1, 1958. The amendments to the existing contract putting these changes into effect were signed by your officers under protest. The Medicare contract has been renewed effective February 1, 1959 without a special meeting of the House of Delegates since the poll of the county societies was predominately opposed to such a meeting. The new contract is a short term one with the idea of giving the new Congress an opportunity to take corrective measures. Our future policies and actions in connection with Medicare will depend greatly upon whether any such corrective measures are taken.

In addition to our protest against these changes of October 1, we held conferences with several of our Congressmen. The most productive was that with Mr. Robert Sikes, who suggested that the Association put its major objections and its suggestions for correction in writing to the appropriate committees of the Congress. If this were done, he agreed to see that the hearings were held.

The Board was also honored by being given the privilege of reviewing and approving in principle the recommendation of the Governor's Citizens Medical Committee on Health. The Board commended the Committee upon the completion of its most extensive study.

### Recommendations

**REVISION OF CONSTITUTION AND BY-LAWS.**—In accordance with a directive of this House, the complete and comprehensive revision of the Association's Constitution and By-Laws has been completed. Copies of this proposed revision were made available to the presidents of each of the county medical societies well in advance of this meeting of the House of Delegates. Copies will be made available to each delegate and the matter will be referred to a special reference committee on Charter and By-Laws. Any delegate or other interested member of the Association is urged to present his suggestions or recommendations to this reference committee.

The Association's attorney has advised that according to Florida statutes, the Charter granted by the State should serve as the constitution. This change is recommended. To accomplish it, two resolutions are offered, one to authorize the necessary amendments to the Charter and the other to authorize substitution of the Charter for the present Constitution.

**RESOLUTION OF  
FLORIDA MEDICAL ASSOCIATION, INC.  
TO AMEND ARTICLES II, VI AND VIII  
OF THE CHARTER**

RESOLVED: At this meeting of the House of Delegates properly held and called at which a quorum is present, that ARTICLE II of the Charter of the Association be amended to read as follows in lieu of the present Article:

**ARTICLE II**

The general nature of the objects of the corporation is to promote the science and art of medicine and the betterment of public health; to unite the medical profession of Florida into one compact organization and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical education; to strive for the enactment, preservation and enforcement of just medical and public health laws; to promote friendly relationships among physicians and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies, and to carry out these objects of the corporation as a business league not organized for profit, and no part of the net earnings shall inure to the benefit of any private member or individual, as an exempt corporation not for profit within Section 501 (c) U. S. C. A., Internal Revenue Code of 1954.

BE IT FURTHER RESOLVED: That Article VI be amended to read as follows in lieu of the present Article:

**ARTICLE VI**

The affairs of the corporation are to be managed by: a President, a President-Elect, a Vice President or several Vice Presidents if so provided by the By-Laws, a Secretary, a Treasurer, the Immediate Past President, a House of Delegates of not less than three delegates or such additional number as is fixed in the By-Laws, a Board of Governors constituted as provided in the By-Laws and an Executive Committee constituted as provided in the By-Laws. Each officer and member of the House of Delegates and of the Board of Governors and of the Executive Committee, shall be elected or appointed at the time and in the manner fixed in the By-Laws.

BE IT FURTHER RESOLVED: That Article VIII be amended to read as follows in lieu of the present Article:

**ARTICLE VIII**

The By-Laws of the corporation shall be made, altered or rescinded by the House of Delegates in the manner fixed by the By-Laws.

After discussion, upon motion duly made, seconded and carried, each of the foregoing amendments of Articles II, VI, and VIII and said Resolution were adopted.

BE IT FURTHER RESOLVED: That Article XI be eliminated as being surplusage.

**RESOLUTION OF  
THE FLORIDA MEDICAL ASSOCIATION, INC.  
RELATING TO THE CONSTITUTION**

RESOLVED: Whereas the Association has a Charter as a non-profit corporation and By-Laws adopted pursuant thereto, in which Charter and By-Laws all of the provisions of a document designated "Constitution" of the Association have been included and the provisions

found in the Constitution should therefore be eliminated by amendment;

RESOLVED: At this meeting, properly held and called of the House of Delegates at which a quorum is present, by a two-thirds vote of the delegates registered at this annual meeting, that the Constitution of the Association consisting of articles I through XI both inclusive, be amended by eliminating each of said Articles, as the Charter of the Association and the By-Laws of the Association include all of the provisions contained in the Constitution that are necessary and proper.

AND FURTHER RESOLVED: That this Resolution be referred to the component county societies for ratification during the ensuing year, each component society ratifying by a majority vote of its membership present at any regular meeting and that three-fourths of the component societies vote in favor thereof during that year.

These resolutions are also being referred to the reference committee on Charter and By-Laws.

SITE FOR 1960 MEETING.—It is the recommendation of the Board of Governors that Jacksonville be designated as the site for the 1960 annual meeting. It is believed that by utilization of the new Robert Meyer Hotel in conjunction with the nearby George Washington Hotel, the facilities will be adequate. Both hotels are holding the date of April 8 to 12 pending action by this House of Delegates. This early date has been selected, being one of the few available and one which did not schedule our meeting close to the AMA meeting to be held next year in Miami Beach.

*Sub-Committee to Board of Governors  
on Veterans' Care*

FREDERICK H. BOWEN, *Chairman*

During the calendar year 1958, the Veterans Administration paid \$338,355.00 to the physicians of the State of Florida for services to 32,473 veterans.

During the year, our Committee re-negotiated our fee schedule with the Veterans Administration. We feel that the fees are inadequate in many cases, but we are unable to find the means for elevating our fees. If we cancel our fee schedule with the Veterans Administration, our fee for service in Florida would revert to a national fee schedule, and this is in most respects lower than the Florida fee schedule.

*Sub-Committee  
to Board of Governors on Asian Influenza*

RICHARD G. SKINNER JR., *Chairman*

This Committee was established in August, 1957, to act in an advisory and planning capacity before and during a possible Asian Influenza epidemic during the winter of 1957-58.

There is no activity to report for the past year.

Since the need has apparently been concluded, it is recommended that this Committee be abolished.

*Sub-Committee to Board of Governors on  
Commercial Health Insurance*

DUNCAN T. McEWAN, *Chairman*

The first meeting of the Commercial Health Insurance Committee was held in the office of the Florida Medical Association in Jacksonville on Dec. 13, 1958. The Committee had been appointed by President Annis at the request of the Health Insurance Council.

It has long been felt that a closer relationship should be established between the medical profession and the commercial insurance companies to help solve our many mutual problems to the best interest of the American public. It was thought that this could best be done by discussing these problems with the component county



medical societies and then meeting with the Health Insurance Council to form a specific program.

This program is now under way.

### SUPPLEMENT

This supplement to the Report of the Board of Governors is in addition to and a part of the original report as printed in the Handbook. It is submitted to include a meeting of the Board held in Jacksonville on March 22, 1959.

### Resignations

The Board accepted the resignations of Edward Jelks, M.D. from the Board of Governors with commendation and appreciation for his outstanding services to the Association; Louis M. Orr, M.D. as an AMA delegate from Florida and Mr. Ernest R. Gibson from the Association's staff.

### Blue Shield Nominations

At the request of the Nominating Committee of Blue Shield of Florida, and in accordance with its By-Laws, two nominees were selected from the three names submitted for each vacancy on the Blue Shield Board of Directors for presentation to the active members at its annual meeting on May 4, 1959.

### Contract Medicine

The report of the Board's special committee on contract medicine was approved with commendation for Dr. Edward R. Annis, Chairman. This report is submitted for consideration by the House of Delegates and reads as follows:

In compliance with the request of the Board of Governors to re-evaluate the Association's policy regarding members of the FMA engaging in contract medicine and to recommend policies the following report is submitted:

I. The Florida Medical Association should reaffirm its policy that the Principles of Medical Ethics and Opinions of the Judicial Council of the AMA shall be binding upon all of its members. Specific reference is made to Principle 6:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

II. To implement the above principle, it is recommended that the Association adopt the following statement of policy and principles:

A. *Statement of Policy*—It is the right of a patient to be able to select a private physician of his choice without economic factors interfering in his selection. It is also the right of the physician to choose whom he will serve except in emergencies when he should render service to the best of his ability.

The free practice of medicine must make possible an established physician-patient relationship without the interference of any third party, and should make possible wholesome competition and unrestricted initiative among physicians.

The laws of the State of Florida require that all who practice medicine in this state be licensed by the state. A corporation may not lawfully practice medicine, even in the case where all its members are licensed practitioners, since the corporation itself, as a legal entity, cannot be licensed. Neither may any organization, corporation, hospital or other person incapable of obtaining a license lawfully practice medicine by the expedient of hiring licensed practitioners and selling their services.

### B. Principles

1. That no hospital shall be permitted to engage in any form of contract practice with an individual member of FMA or groups of individual members of FMA to provide medical

service or for any purpose other than that of pure hospitalization.

2. That no member of FMA shall permit a hospital to offer for price any of his professional services.
3. That in no case may a hospital charge a patient for other than the use of its facilities and material. No medical fee for professional services rendered by members of FMA may be charged and retained by the hospital.
4. That emergency and accident cases may have first aid only administered at the hospital and the physician selected by the patient must be immediately notified. In no case shall a patient able to pay be admitted to the service of a hospital staff member without the request of the patient's own physician, if there be one.
5. That patients who are covered by compensation, health or accident insurance cannot be considered as indigent.
6. That no one but strictly indigent or medically indigent patients shall be admitted to free charity clinics except in emergencies. Principles to determine medical indigency shall be determined by the respective component county medical society of the FMA.
7. Members of FMA may not continue to serve on the medical staff of a hospital or charity clinic, other institution or agency which violates these principles.
8. This shall not be construed as denying any member of the FMA the right to provide medical service to those who make no direct or indirect payment for such service while the physician acts as an agent or employee of:
  - a. A charitable, voluntary, health organization.
  - b. A government agency required by law to offer care without charge to certain classes of people.
  - c. A teaching or other institution when the care is incidental to and a necessary part of medical instruction or valid research.
  - d. An employer in industry to the extent necessary to protect employees from industrial injury or in rendering such first aid as may be needed to prevent the aggravation of injuries when occurred.
9. Neither shall anything in this statement be construed to deny any member the right to have his fees collected on his behalf and in his name by an unlicensed person and to pay that person reasonable recompense for that service.

### III. Implementation

It shall be the responsibility of the Judicial Council, in consultation with the Board of Governors of the Florida Medical Association to enforce this statement of policy and principles as provided for in the proposed Charter and By-Laws of the Association.

Respectfully submitted,  
Edward R. Annis, Chairman

### Proposed Charter and By-Laws

The proposed Charter and By-Laws were reviewed again by the Board of Governors and corrections which were suggested by the Association officers, county medical societies and staff, were included. A revised copy will be included in the delegates' packets.

### Assistance to Committees

The Board reviewed reports of the following committees: Conservation of Vision, Aging, Medical Schools Liaison, Child Health, and Blue Shield Liaison. These reports will be contained in the supplemental reports of the respective committees.

### Reorganization of The Journal

Since the Handbook went to press over two-thirds of



the county medical societies have approved the constitutional amendment which would place the supervision and managing of The Journal under the Board of Governors.

### Medicare

The Board requested representatives of the Association to appear before the Appropriations Committees of Congress and present the Association's view regarding the improvement of the Medicare program. A report to the House regarding this will be contained in the supplemental report of the Medicare Mediation Committee.

### Public Relations Report

The annual report of the Public Relations Liaison Member was received as information and reads as follows:

The continued promotion of the principles contained in the Association's long range public relations program adopted by the House of Delegates in 1954 has been the object of your liaison member's major activity during the past year. In my opinion, these principles continue to provide a necessary basis for a strong program for the present and the foreseeable future.

In implementation of the program, we have emphasized positive activities directed to the general public, news media, governmental agencies, medical and nonmedical organizations and groups and individual physicians. The over-all objective of these numerous activities was, as in the past, to extend to the public and the medical profession a constructive understanding of the Association's program, policies and services.

Considerable stress has been placed upon encouraging county medical societies to carry out local counterparts to certain projects conducted initially on a state level. It is gratifying to note that the past year saw the largest number yet of medical society sponsored public fair exhibits and science fair awards. The former activity is designed to present authentic health information to the public; the latter to stimulate promising young students to enter the field of medical science. The Woman's Auxiliary to the Association has made a noteworthy contribution to both of these projects through its participation on state and county levels.

The rural health program is progressing through the Association's leadership in the Florida Committee on Rural Health, a joint group composed of statewide organizations concerned with this field. A number of constructive activities have been initiated and are being undertaken as a result of action by this committee, in which medicine is in close cooperation with agriculture.

The program of liaison with The Florida Bar has seen an additional medicolegal institute and an institute on hospital law. Important steps have been undertaken in achieving improved medical testimony, a field in which the medical and legal professions have undergone considerable criticism. I am pleased to report that a number of county medical societies have established continuing cooperative programs with local bar associations.

Our regular public relations activities such as the distribution of films, articles, programs and other materials and information to news media, organizations and the general public continue to be well received and should be continued and expanded wherever feasible.

In order to achieve any lasting favorable effect, each and every public relations activity undertaken by the Association should be motivated only by what is in the best interest of the patient. Only by adhering to this principle without exception can the objectives of our program be approached.

Recognizing that this report is but a brief summary of a few of the many activities conducted, it should be pointed out that a more complete report will be contained in the Public Relations Department's

section of the annual report of the Secretary-Treasurer and the Executive Director.

I wish to express my sincere appreciation to the officers, members of the Board, House of Delegates, Public Relations Advisory Committee, standing and special committees, individual members and the headquarters staff for their kind support and cooperation during the past and previous years.

Respectfully submitted,  
Edward Jelks  
Public Relations Liaison  
Board of Governors

Dr. White: "The report of the Committee on Necrology and its supplement are approved."

The House stood for a moment of silent reverence for those who have passed on during the year.

Dr. White: "I move the adoption of this portion of the report."

Motion seconded and carried.

### Report of Committee on Necrology

LEO M. WACHTEL, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Donald C. Anderson, West Palm Beach  
Samuel Aronovitz, Miami  
J. Lunsford Boone, Green Cove Springs  
M. Q. Burns, Blountstown  
Melton D. Council, Vero Beach  
Frank Denniston, Ft. Lauderdale  
Herbert Eichert, Miami  
George W. Elarbee, Pahokee  
Theodore R. Failmezger, Clearwater  
Thomas S. Field, Green Cove Springs  
Chester A. Fort Jr., Jacksonville  
Thomas E. Hodgins Jr., Jacksonville  
Samuel G. Hollingsworth, Bradenton  
Robert L. Hughes, Bartow  
Samuel B. Kleinman, Miami Beach  
A. Buist Litterer, Miami  
Vincent C. Lo Popolo, Cross City  
George S. McClellan, Pompano  
B. Martin McClosky, Tampa  
Douglas D. Martin, Tampa  
Joseph E. Rose, Pensacola  
David D. Sher, N. Miami Beach  
DeWitt T. Smith, Gainesville  
James S. Smith, Miami  
Efton J. Thomas, Miami Beach  
Joseph E. Thomas, Plant City  
John C. Vinson, Ft. Myers  
Carol C. Webb, Pensacola  
Robert Y. Wheelihan, Riviera Beach  
M. C. Wilson, Miami  
Sanford A. Winsor, Pompano Beach

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

### Supplement

Since the Handbook for Delegates was printed the Association has lost the following members through death:

Walter L. Alspach, Miami  
George M. Floyd, Gainesville  
Crowell W. Johnston, West Palm Beach  
Paul Kells, Miami

Dr. White: "The report of the Committee on Advisory to Woman's Auxiliary is approved as presented."

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Zellner.

Motion carried.

### **Report of Committee on Advisory to Woman's Auxiliary**

L. WASHINGTON DOWLEN, *Chairman*

The Woman's Auxiliary has functioned very efficiently and harmoniously this past year under the very able leadership of Mrs. Lee Rogers Jr.

There has been no formal meeting of our Committee. We have been consulted on several occasions during the year, have offered to participate whenever necessary and have assisted the Auxiliary when possible.

We wish to commend the Woman's Auxiliary for the outstanding job it is doing for our profession and the public in Florida.

Dr. White: "The Report of Council and supplement are approved as submitted.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Robert L. Tolle.

Motion carried.

### **Report of Council**

WARREN W. QUILLIAN, *Chairman*

An organizational meeting of the Council was held at the Americana Hotel following the annual session of the F.M.A. on May 13, 1958. Previous action by the Board of Governors and House of Delegates approved discontinuance of the Medical District Meetings for the coming year. The necessity for an Interim Meeting of the Association is determined entirely at the discretion of the President and Board of Governors.

It was decided that emphasis would be placed upon the initiative, tact and zeal of members of the Council to solve problems within their District at the county level. They have visited the county societies in their Districts upon invitation. Since our duties are largely judicial and to serve as liaison to the State organization through the county societies, we have maintained close contact with the Association headquarters at Jacksonville. The efficient management of that office during the past year has averted many difficulties which might otherwise have arisen. We wish to thank the Officers and Committees of the F.M.A. for the zealous devotion to duty and for the intelligent manner in which they have met their responsibilities.

Our next meeting will be held prior to the May (1959) meeting of the Association. Any developments will be submitted as a supplemental report to the House of Delegates at that time.

### **Supplement**

The Council has considered the request and desire of the Highlands County Physicians to form a separate component county medical society to be known as the Highlands County Medical Society. It is our recommendation that this request be granted and that the name of the DeSoto-Hardee-Highlands-Glades County Medical Society be changed to DeSoto-Hardee-Glades County Medical Society.

Also considered was a request from the licensed physicians of Charlotte County to affiliate themselves in a component society to be known as the Charlotte County Medical Society. It is our recommendation that this request be granted since there are five practicing

physicians in Charlotte County at this time and that this county society be encouraged to increase the membership as rapidly as possible. It is further recommended that the name of Lee-Charlotte-Hendry County Medical Society be changed to the Lee-Hendry County Medical Society.

Dr. White: "The Report of the Committee on Advisory to Selective Service is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Tolle.

Motion carried.

### **Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists**

J. ROCHER CHAPPELL, *Chairman*

Your Advisory Committee to Selective Service for Physicians and Allied Specialists experienced no activity during the past year.

Dr. White: "The report of the Committee on Civil Defense and Disaster is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Mathers.

Motion carried.

### **Report of Committee on Civil Defense and Disaster**

W. DEAN STEWARD, *Chairman*

During the nine months prior to the submission of this report, there have been no committee meetings; however, there has been some committee activity. The members of the Committee, along with the Chairman, attended Regional Defense organizational meetings in October, 1958. These were held at Lantana, Tampa, Orlando, Chattahoochee and Tallahassee. The Chairman attended the Orlando meeting, and the other members attended in their respective districts.

Following this each Committee member received a copy of the new organizational setup as issued by the Medical Director for Civil Defense, Dr. L. L. Parks of Jacksonville. The new setup is on the basis of regions with six such areas in the state. Each of these has a deputy District Director, and a table of organizations has been set up outlining the association of auxiliary services in case of disaster. The object of this new setup is to make each regional area interdependent among the component counties. At the time of the submission of this report each County Medical Society Civil Defense representative should be aware of the part his county plays in the overall operational setup.

In addition, an editorial was prepared by the Chairman of this Committee, and it was published in the January issue of the State Medical Journal.

It is the feeling of the Chairman of this Committee that much remains to be done at all levels in the Civil Defense setup, but it is urged that each county have not only a Civil Defense setup with an evacuation plan for its medical and auxiliary personnel, but that each county society have an organization to cope with local disaster.



Dr. White: "The report of the Advisory Committee to Blue Shield and supplement are approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Tolle.

Motion carried.

## Report of Advisory Committee to Blue Shield

HENRY J. BABERS JR., *Chairman*

I. On Oct. 5, 1958, your Committee of Seventeen met in Jacksonville and made its final review of the new contract approved by the House of Delegates in May 1958. We submitted our recommendations to the Board of Governors of the Florida Medical Association and these were approved by that body on Oct. 12, 1958. These final review recommendations were given to Blue Shield of Florida and it has done a wonderful job in getting the contract in final form for publication.

Based on our recommendations, the Blue Shield organization has developed a new participating physician's manual. This new handbook or manual gives all information possible concerning Blue Shield and then lists the fee schedules of the new (Type A) and the present (Types J and F) contracts. We feel that this new contract is very fine, that it is fair and equitable as far as fees are concerned, and that it is a wonderful thing for the public if they can only understand. We should all do everything we can to make it successful; we have labored long and hard to make this new proposition fair to public and doctor alike and we hope that it will be accepted well by the public. It is the best they can get for the money.

II. When the Type A contract becomes successful, we can work out a prolonged illness or extended benefit contract which can be superimposed on the basic one.

III. Study is continuing on insurance coverage for the older age group and on national Blue Shield contracts.

IV. A Professional Relations Department has been set up in Blue Shield. The Department has the confidence of the Committee of Seventeen and will make sure that our problems are understood and that our suggestions, criticisms and philosophies will be received and be given consideration.

### Supplement

The new type "A" Blue Shield contract was put into final form as recommended by your Committee and approved by the Insurance Commissioner with one exception (service benefits will still apply when the patient carries other health insurance). This contract is now available to the public.

Your Committee recommended and the Board of Governors approved the Florida Blue Shield entering into a uniform national contract to provide coverage for organizations having employees in more than one state. This national account agreement will be on an indemnity basis.

Dr. White: "The report of the Medicare Mediation Committee and two supplements, containing Dr. Dobbins' recommendation that the Florida Medical Association continue under Medicare, is approved with the provision that the Government, in the opinion of the Medicare Mediation Committee, show material progress in working out an insurance program such as Dr. Dobbins presented. Unless this is done in a

reasonable time, it is recommended that the Florida Medical Association no longer continue under the Medicare program. The committee also wishes to commend Dr. Dobbins for his diligent and tireless work on this Medicare Mediation Committee.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Thomley.

Dr. Steward: "I believe this should be clarified. I would like to know what a 'reasonable time' is."

Dr. Annis: "I believe this can be clarified if you will allow me to recognize Dr. Dobbins."

Dr. Dobbins: "I want to thank Dr. White and his committee for their patience in hearing our discussion of this problem, both on our side and Dr. Dean Steward's side, whose opinion I respect. I want to thank you for the faith in our Committee and want to emphasize that this is a working Committee and point out that the Committee is an instrument of the House of Delegates and we wish to carry out your recommendations. I don't think the Committee should be asked to decide on a policy, since we have enough troubles of our own. Our main interest is to put stability and uniformity into the program. Our Committee believes we have more to gain by keeping our foot in the door. This House of Delegates should make the decision. I would like to amend the motion that the Florida Medical Association continue to cooperate with the Office for Dependents' Medical Care until the next meeting of the House of Delegates provided there are no more cutbacks in the program. The Medicare Mediation Committee will continue to work for stability and uniformity in the program."

Dr. Steward: "Mr. President, I don't think it is the cutback that we are concerned about. It is the principle, that is, whether or not we are going to have socialized medicine, not whether we are going to get two, or four, or eight million dollars from the Government.

"I think the recommendations of the Committee are the result of considered deliberation. However, I do believe we should not put in this amendment that we base it on cutbacks. We could put in a recommendation that if the Federal Government will change to an insurance program within the next year, we will continue to go along with it. If not, we will reject the program. I wish to recommend that we continue with Medicare until the next meeting of the House of Delegates, provided a definite plan is



made for an insurance program and it is ready to present to us at that time."

Dr. Annis: "We will vote on Dr. Dobbins' amendment."

Motion carried.

Dr. Annis: "We will now vote on the amended motion."

Dr. James T. Cook Jr.: "What Dr. Steward is recommending is almost exactly what the committee recommended except he said one year as a reasonable time. In other words, they said go into an insurance program or we will pull out."

"Immediately after the Medicare report in the Handbook is a resolution from Orange County. It requires that the House of Delegates decide policy. Dr. Steward and some other members of the House certainly do not wish to perpetually contract themselves to Medicare. I would like to go back to the original committee report and make a motion—"

Dr. Annis: "Dr. Dobbins motion has already been passed."

Dr. Sappenfield: "I was on this reference committee. We believed in giving this type of report that we should be progressive and aggressive. If we accept Dr. Dobbins' method we would not be taking an aggressive attitude."

Dr. Zellner: "I move that the amendment be reconsidered."

Seconded by Dr. Cook.

Dr. Annis: "Did you vote for the amendment?"

Dr. Zellner: "I did not."

Dr. Donald F. Marion: "I voted for the amendment and I move that it be reconsidered."

Seconded by Dr. Steward.

Motion carried.

Dr. Annis: "At this time we will go back to Dr. White's motion, which we will ask him to read again for clarification."

Dr. White again read the recommendation of the Reference Committee.

At Dr. Annis' request, Dr. Dobbins again read his amendment.

Dr. Tolle: "I was on this committee, and it was our belief that this action should be taken, but we also passed the resolution of the Orange County delegation. I would like to amend the motion that instead of saying 'no further cut-backs', no agreement with the Government be entered into after the expiration date of the present contract without the express authorization of the House of Delegates of the Florida Medical Association."

Seconded by Dr. Zellner.

Dr. Cecil Peek: "May we have the opinion of the Reference Committee about this amendment, since they had an opportunity to study this?"

Dr. White: "The Reference Committee approved the resolution of the Orange County Medical Society."

Dr. Sappenfield: "That is true, but you still do not adopt the aggressive attitude. We would like to push the insurance program, and if it is not done, withdraw from Medicare."

Dr. Steward: "We could specify a year. Then if they do not come up with an answer in a year, tell them we are through. If they will follow Dr. Dobbins' recommendation and come up with an insurance program in a year, we will cooperate; otherwise we are through with this form of socialized medicine."

Dr. Tolle: "May I add that to my amendment?"

Dr. Dobbins: "I did not mean to get into a discussion of Medicare. I was merely trying to put this decision on the House of Delegates and not on the Medicare Mediation Committee. Therefore, I will withdraw the amendment which I proposed and offer as a substitute that a 'reasonable time' be changed to read 'until the next meeting of the House of Delegates'."

Dr. Peek: "Since the amendment has been withdrawn, doesn't that automatically withdraw the amendment to the amendment?"

Dr. Tolle: "I will be happy to withdraw."

Dr. Steward: "May I make an amendment to Dr. Dobbins' amendment, to state specifically that after that time Medicare will be dropped?"

Dr. Melvin M. Simmons: "In my part of the room we are so confused—we want to be sure what we are voting on and I would like to clear the air. It seems to us there are two points we need to determine. The first is, how long will we continue on a temporary basis? The second is, shall we or shall we not insist on the conversion of Medicare to an insurance program?"

Dr. Annis: "The only change being made is to define a 'reasonable time' as being until the next meeting of the House of Delegates, which means that is as long as we can continue."

Motion carried.

Dr. Annis: "We will now vote on the motion as amended."

Dr. Simmons: "I would like to offer another amendment that during this time satisfactory

work be accomplished in converting to an insurance program."

Dr. Annis: "That is in the reference committee recommendation."

Dr. Simmons requested that Dr. White read the recommendations again. This was done.

Motion carried.

Dr. White moved for adoption of this portion of the report as amended.

Seconded by Dr. Herz.

Motion carried.

## Report of Medicare Mediation Committee

BURNS A. DOBBINS JR., *Chairman*

During the period May 1, 1958 to Jan. 1, 1959, the Medicare Mediation Committee held six meetings—one at the Americana Hotel in Bal Harbour, one at the Health Department Building in Gainesville, and the others at the F.M.A. Building in Jacksonville. Attendance at each meeting has been excellent. Claims totaling 17,906 have been paid by Blue Shield as fiscal administrator during this time. This represented a total of \$1,479,557.63 paid to Florida physicians.

The Committee considered 799 claims between May 1, 1958, and Jan. 10, 1959. Many hours have been spent by each member both in and out of Committee meetings considering these claims.

With all the time that members of the State Committee have contributed, the task would have been impossible without the tremendous support received from the County Committees. These local groups have become an integral part of the Medicare organization and have been most cooperative, without exceptions. The State Committee is most grateful for their aid.

The Chairman attended a conference called by the Defense Department on Aug. 8, 1958 in the Pentagon. At this meeting the cutbacks in the program effected Oct. 1, 1958 were unveiled. This curtailment has made the administration of Medicare much more difficult and has led this Committee, with the approval of the Board of Governors, to make the following recommendations to Congress:

1. The Advisory Committee of the A.M.A. should be consulted more frequently and always before changes, such as those effected 1 October 1958, are made.
2. Since the dependents of members of the uniformed services are not, themselves, members of the armed services, it is believed that the best solution would be to provide an insurance program for those dependents, with service-type coverage up to a certain pay grade or rank.

In the event that a separate insurance program is not feasible, it is recommended:

1. That the Defense Department be relieved of the responsibility for administering the Medicare program. It has been pointed out above that dependents are not members of the armed services and there is no valid reason why their care should be under the jurisdiction of the Defense Department where it is subject to constantly changing personnel. In the short time of a little over two years both the officer in charge and the executive officer of O.D.M.C. have been changed.
2. That a program of group insurance, underwritten by the Government, be established in accordance with Section 202 of Public Law 569, under the jurisdiction of the Department of Health, Educa-

tion and Welfare. Personnel in this Department would not be subject to constant rotation.

3. That this group insurance program should have an across-the-board deductible feature. This amount should be larger where private medical facilities are elected so as to encourage the use of presently existing military facilities.
4. That the Medical Association State and County Committees, as presently established, continue to help in the administration of the program by determining that claims are proper charges for the area and service rendered.

At the request of the F.M.A. Board of Governors, the Chairman attended a meeting Dec. 1, 1958, in Minneapolis, called by the Federal Medical Services Committee of the A.M.A. The different views and ideas of members of other state associations were quite illuminating.

This report would not be complete without pointing out the excellent cooperation and help the Mediation Committee has received from the Association staff and particularly that of Mrs. Mae Mason and Mr. Ernest Gibson. They have been most gracious in taking care of details. Mr. N. G. Johnson, the Medicare coordinator of Blue Shield, has attended every meeting and created a real link between the Committee and the fiscal agent.

### Supplement 1

*Testimony Prepared For:  
Subcommittee on Department of Defense  
Committee on Appropriations  
U. S. House of Representatives*

Mr. Chairman:

I am Burns A. Dobbins, Jr., M.D., a practicing physician in Fort Lauderdale, Florida. I am chairman of the Medicare Mediation Committee of the Florida Medical Association, and am speaking for that Association today. I have been on this committee since June of 1957 and was one of the FMA's three-man team that negotiated the since-amended contract with O.D.M.C. in January, 1958. For the record, I have received \$140.00 in fees from Medicare since its beginning in December, 1956, so my personal financial interest is quite small.

Florida is the third largest participant in the Medicare program and we feel that the Florida Medical Association has had experiences and some opinions which may be of some value to this committee in planning for the future appropriations and administration of the "Dependents Medical Care Act."

Public Law 569 was passed by the 84th Congress for the expressed purpose of creating a higher morale in the armed services and providing more uniform medical care for dependents of the various branches of the services. There have been different interpretations of the word "uniform" as used in this act. To us, after careful reading of the phraseology, it means the same medical care, both as to type and amount, to all dependents of the various branches of the armed services.

We feel that the drastic curtailment put into effect October 1, 1958, has worked directly against both purposes of the law. No longer is medical care uniform among dependents—those living with sponsors near military medical facilities have a decided advantage, and profit much more from the program. At the same time, the dependents of servicemen who are overseas and away from their families are being discriminated against in that a number of medical services are denied them unless the dependents are living in close proximity to a military medical installation. This situation works against morale, the other purpose for which the Congress intended Public Law 569, because of the increased concern when a serviceman, separated from his dependents, knows that Medicare will not provide the same medical care as when they are with him.

Perhaps refinements and changes in the program were definitely necessary both to reduce costs and perfect its administration. Although the O.D.M.C. has done a most commendable job in organizing the tremendous program



of Medicare, we feel that the Defense Department acted too hastily when the "crash program" of curtailment was put into effect October 1, 1958.

The reasons advanced for the necessity of reducing Medicare were quite valid in that appropriations of funds were not made for the rapidly rising costs of the program. Congress was rightly concerned with these costs, but it is hard to conceive that Congress was putting finances above the health and medical care of some of the dependents involved when the purpose of Public Law 569 was to provide more uniform medical care. It is our belief that Congress intended for the Defense Department to very carefully review Medicare, institute refinements not contrary to the purposes and intentions of the act, and seek a deficiency appropriation of proven necessity.

In either event the changes instituted October 1, 1958, have worked a definite hardship on many dependents and have made Medicare much more difficult to administer on the civilian side.

Naturally there has been some confusion on the military's part in properly following the revised Medicare benefits, but these people are accustomed to sudden changes in policy and different forms to fill out. It has been most difficult to orient civilian physicians who who have an innate aversion to military forms and government red tape.

Now that all dependents are divided into two categories, one group who lives with their sponsor and the other who lives apart, a dependent of the first group can seek civilian medical care only if she has a properly filled out permit signed by the sponsor's commanding officer or his designee. However, this permit is not a government order and carries no guarantee of payment. It is the civilian physician's responsibility to decide whether or not the medical service sought is compensable under the program. Servicemen and their dependents are taught to believe that the commanding officer knows what he is doing and it is often difficult to convince them that the permit is invalid and the medical costs will not be covered by Medicare. This fact has discouraged many private physicians from participating in the program.

Officials of the Defense Department, in testimony before Congress last year expressed much concern over the decreased use of military medical facilities since the inception of Medicare. Waste of existing facilities plus the lack of patient material for the residency training program were the principal causes of alarm. As for the latter reason, we can't feel too much concern because it is and has always been possible for the armed service to procure necessary training facilities in civilian hospitals.

However, as taxpayers we are greatly interested in the waste of space and personnel experienced in presently existing service medical establishments since Medicare began. Certainly these hospitals have the finest physical facilities with excellently trained personnel, both professional and ancillary. Then just why have dependents elected civilian hospitals and medical care over military? Perhaps it is time for the Defense Department to take a long penetrating look for the causes of this exodus. Maybe the "art" of Medicine which is such a necessary adjunct of scientific medical care is not being practiced as it should be and patients are not being made to feel that they are individual human beings.

Dependents of members of the armed services are not, themselves, members of these services and should not be coerced into using military medical facilities just because they are not being used to "optimum" capacity or there exists a dearth of teaching material for certain medical specialties. Inducements of more personal attention to each dependent as a person, and reduced costs, as explained later, should be used rather than compulsion to take military medical care or get none.

Members of the Florida Medical Association have a two-fold interest in Medicare—as participating physicians and as taxpayers. As the latter we are acutely conscious of the increasing costs. The six members of the State Mediation Committee contribute one weekend a month when they assemble to mediate questionable

claims. The Committee is supported by a similar group in each county society which studies claims for conformity to local fees and practices. The only cost to the government is the travel expense of the state committee.

Our members have reluctantly gone along with the curtailments instituted unilaterally by the Defense Department in a properly negotiated contract. We do not believe that Congress ever intended to further penalize a man who must serve his country away from his family by prohibiting Medicare from providing full benefits for his dependents. The Florida Medical Association has elected to participate on a temporary basis until Congress has had the opportunity to study the program and express its wishes. We certainly believe that Congress will feel as we do that the proper care of the individual must be the prime consideration.

We certainly are not opposed to reducing Medicare costs; we feel that this can be done in such a manner that the original purpose of the Public Law 569, uniform medical care, will not be lost and the program can be stabilized as to the medical care each individual dependent can expect. We believe that a definite insurance plan or plans, which is the alternative provided by Congress in Title II, Sec. 201 (a) of Public Law 569 will provide this stability and furnish the Defense Department and Congress with an accurate estimate of the annual cost based on the estimated strength of the armed forces. Such a policy could even be offered on an attractive voluntary basis to each individual with the government bearing the major expense and the serviceman participating financially to a much lesser extent. A deductible feature could be incorporated as a restraint on excessive demands for medical care as provided in (c) and (d), Sec. 103, Title I of Public Law 569.

With a definite insurance plan, dependents would know just what medical care to expect and civilian physicians could be certain of the services for which they would receive compensation. Such a plan would be based on the medical care Congress intends to provide for the health of the individual and not on the finances of the particular year. If at some future date Congress should decide it was necessary to reduce the cost of the program to the government, the ratio of the government's financial participation in each policy could be reduced, and that of the individual raised so that the medical benefits to the individual would remain constant.

In order to encourage those dependents who are in the proximity of a military installation to use the medical facility therein the deductible amount could be considerably less than the amount necessary for care in a civilian facility. Under this plan any dependent could have his choice and all dependents regardless of residence would have available uniform medical care as Congress intended them to have.

These insurance plans could be administered either privately on a competitive bid basis or by the government with a permanent agency. We emphasize a "permanent agency" because although the present O.D.M.C. has done a magnificent job in handling the organizational problems of Medicare, it is necessarily subject to changing military medical personnel. These changes are necessitated by either rotation or retirement. As explained earlier, dependents are not members of the armed services and we can see no more valid reason for their medical care being supervised by the military than any other of their daily living requirements. Therefore, the Defense Department should not be burdened with the responsibility of administering the medical care program for these civilians.

Mr. Chairman, please permit me to express my personal gratitude and the appreciation of the Florida Medical Association to you and your committee for your patience in hearing the views of the Florida Medical Association on Public Law 569. Also I want to assure you of our continued interest in the program.

If there are any questions, we will welcome the opportunity to discuss them.

Respectfully submitted,  
Burns A. Dobbins Jr., M.D.  
Chairman, Medicare Mediation Committee



### Supplement 2

Since the publication of the report of the Medicare Mediation Committee in the Handbook, we now have some more interesting information for the entire period April 1, 1958 through March 31, 1959. We have, for all practical purposes, finished our second year of handling Medicare. The first payments to doctors under the Medicare Program were made in late March and early April of 1957.

During the period 1957-1958, 1,483 cases were reviewed by the Medicare Mediation Committees of the various county societies and the State Committee. During this period in 1958-1959, 1,550 cases were reviewed. In the first year, 1,981 doctors participated while last year 2,069 physicians participated in the Medicare program.

Although, as Chairman, I am making this report, I would like to emphasize that the State Committee is one in which every member works and does his share. Since the Progress Report, the State Committee has held three additional meetings, making a total of nine meetings since the last meeting of the Florida Medical Association. Without the excellent cooperation we have received from every local county society committee, it would have been almost impossible for the total job to be done.

Both the County and State Committees are in a somewhat difficult position, in that we are anxious to see that the individual physician receives all the payments to which he is entitled and at the same time see that these claims come within the provisions of the contract between the Florida Medical Association and the Office for Dependents' Medical Care. The position of mediation is not always an enviable one. Although many physicians carry their money on their hip, it is the thing closest to their heart and naturally resent the entering of a third party into their money matters.

Payments to individual physicians have varied throughout the State and have ranged from \$0.00 to \$36,101.00 to individuals during 1958-1959. The highest payment during 1957-1958 was \$27,809.00. During 1958-1959 \$2,071,604.08 was paid to Florida physicians as contrasted to \$1,909,042.77 in the 1957-1958 period. These amounts represented payment for 24,348 claims last year and 24,758 claims in the preceding year.

Almost every type of medical and surgical care imaginable has been covered by Medicare during the past year. The various types of cases have been a real revelation to me. Many of the conditions I have not heard of since medical school and some of them I have never heard of; it has been quite an education. I am going to recommend to Dr. Sias, the present president of the Florida Academy of General Practice, and Dr. Glenn, the incoming president, that the Academy give serious thought to allowing credits for the educational value of participating in the work of these County and State Medicare Mediation Committees!

As pointed out in the published report, your State Committee and the Board of Governors have not been pleased with the revisions and cutbacks made in the program October 1, 1958. They feel that there should be more stability in the program such as could be provided through a definite policy for dependents. Through the good offices of U. S. Representative Robert Sikes, a hearing was arranged before the Subcommittee on Defense of the House Appropriations Committee April 23, 1959. At the request of the Board of Governors, the chairman of the State Committee accompanied by Dr. Al Kennedy from the Board of Governors and Mr. N. G. Johnson appeared before this committee in Washington. A copy of the testimony expressing the feelings and views of the Florida Medical Association has been enclosed in your delegates' packet, so as not to prolong this report.

I am happy to report that we were very cordially received by this committee of seven or eight Congressmen and they showed a great deal of interest in our proposal. Congressman Sikes seemed extremely well pleased with our testimony and stated that he believes

the Subcommittee certainly had some interesting facets of the Medicare Program to think about which it had not heard before. The Committee is extremely grateful to the members of the Florida Medical Association who first contacted Congressman Sikes on this matter, and to him for arranging the hearing.

Whether or not any action will be taken following our testimony I cannot say. I do not feel that there will be any further cutbacks at the present time. There are some indications of liberalizing the program a little more, but we are striving for stability in Medicare so that both physicians and dependents will know and understand the various provisions. Even though we are not happy with the present status of Medicare, the Committee feels that the Florida Medical Association should continue to go along with the Office of Dependents' Medical Care under the present amended contract and strive for stability in the program because:

1. The withdrawal of the Florida Medical Association from the contractual relationship would not mean the end of Medicare in Florida. Some commercial insurance company would immediately take over as fiscal agent and handle all claims.
2. Although Medicare is of very little interest to many members of the Florida Medical Association, it is of vital interest to a number as shown in previous figures.
3. With the Florida Medical Association's participating in a contract with O.D.M.C., Florida physicians will always have the backing of the State association in the settlement of claims. If claims were handled by a commercial company, it is doubtful if this would be possible.

The committee would like to bring to your attention the fact that our working relationships with the Office of Dependents' Medical Care have been most satisfactory. All members of that office have exerted themselves to cooperate with us. Lt. Col. Rivas has been with us at our annual meeting for the past two years, and I believe is in the audience this afternoon. Col. Rivas is here to answer your questions and give explanations insofar as possible. He will be headquartered at the Blue Shield Booth as will Mr. Johnson, so please feel free to contact him.

The Committee recommends that Blue Shield be retained as fiscal agent for Medicare. Mr. N. G. Johnson, as Medicare coordinator, has done an outstanding job. I know that some of you have become exasperated with him at times, but he is really attempting to look after your interests and is trying to guide you through the maze of government forms which none of us like. The great majority of claims are paid routinely; it is his and the Committee's duty to attempt to fit the others into the book. We are extremely fortunate in keeping the financial matters of the members of our Association in the family, so to speak.

The work of the State Committee has been much smoother this past year due to the excellent organizational ability of Dr. John Milton, the first chairman, who has continued to serve on our Committee as an advisor. His continued help and advice have been appreciated. If you remember, last year, in his calm, cool, collected manner, he peacefully sang his swan song. After one year of trying to fill his shoes, I feel that I am taking off into space. So, if you hear no more from me, you will know that I am "real gone".

Dr. White: "The resolution on Medicare presented by the Orange County Medical Society is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Collins.

Dr. Day: "We take this to mean the House of Delegates has approved signing a Medicare

contract for one additional year."

Dr. Annis: "I think it is clear that this House has approved such negotiations until the next annual meeting of the House."

Motion carried.

## Resolution

### Medicare Contract

WHEREAS, In the two years that the Medicare program has been in operation in Florida, the Government has on two occasions made unilateral changes in the contract it had previously made with the Florida Medical Association; and

WHEREAS, Any contract which is subject to alteration at the will of one of the contractors without consultation with and agreement of the other contractor is in fact and in truth no contract at all; and

WHEREAS, There is no assurance that the Government will not change again at its pleasure, the scope of services covered or in the fees paid to the physicians; and

WHEREAS, We recognize our obligation to provide medical services for the dependents of members of the armed services but we do not recognize that the Medicare program as it now exists is the best or the only vehicle through which these services may be rendered; and

WHEREAS, We do not recognize that the physicians of Florida have any greater obligation in this regard than their colleagues of the Texas Medical, Ohio Medical and Oklahoma Medical Associations, who have refused to continue to sign Medicare contracts with the Government; be it therefore

RESOLVED, That the Orange County Medical Society strongly disapproves of any officers or any agencies of the Florida Medical Association entering into any new Medicare agreement with the Government after the expiration date of the present amended contract without the expressed and specific authorization and approval of the House of Delegates of the Florida Medical Association; and be it further

RESOLVED, That copies of this resolution be sent to the Annual Meeting.

Respectfully submitted,  
Robert W. Curry, Secretary  
Orange County Medical Society

Dr. White: "The resolution that a Certificate of Merit be established by the Florida Medical Association, presented by Dr. Ralph W. Jack, President-Elect, is approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herz.

Motion carried.

## Resolution

### on FMA Certificate of Merit by

RALPH W. JACK, M.D.  
*President-Elect, F.M.A.*

WHEREAS, The Florida Medical Association has no provision for a distinguished service award to be conferred upon its members who render particularly outstanding and meritorious service; and

WHEREAS, It is fitting and proper that suitable recognition be made of such service:

Therefore be it

RESOLVED, That the Association establish an award, designated a Certificate of Merit, to be presented to any member who renders exceptional and outstanding serv-

ice to the Association, to the medical profession and to the public, as laid down in the Principles of Medical Ethics of the American Medical Association; be it

RESOLVED further, That the Certificate of Merit be awarded from time to time as occasion warrants rather than annually or at any fixed interval; and be it

RESOLVED further, That the selection of a member to be so honored shall be made by the House of Delegates, from nominations made by the Board of Governors.

Dr. White: "The nomination of Dr. Edward Jelks to receive the first Certificate of Merit is approved with the change in wording suggested by Dr. Jack, so that in the second paragraph the word 'surgeon' shall be changed to read 'physician'. The Committee also wishes to heartily endorse the selection of Dr. Jelks to receive this honor.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Jack: "I respectfully request that as one of my first official acts I may be privileged to present the first Certificate of Merit ever to be awarded."

Dr. Annis: "We will defer the presentation in deference to Dr. Jack's request."

## NOMINATION

of

EDWARDS JELKS, M.D.

to receive the first

FMA CERTIFICATE OF MERIT

by

RALPH W. JACK, M.D.  
*President-Elect, F.M.A.*

WHEREAS, It is altogether appropriate that Edward Jelks, M.D., of Jacksonville, since 1952 a life member of the Florida Medical Association, be signally honored for his distinguished and outstanding service to the medical profession and the public, and particularly to the Florida Medical Association throughout the forty-two years of his membership in this Association;

WHEREAS, This eminent physician and enthusiastic Floridian by adoption, who was born in Hawkinsville, Georgia, in 1888, who was reared in Macon, Georgia, where he received the Bachelor of Arts degree in 1909 from Mercer University, and who was awarded the degree of Doctor of Medicine by the Johns Hopkins University School of Medicine in 1913, elected to locate in Jacksonville in 1915 and then served two years in the Medical Corps of the United States Army during World War I, retiring from military service with the rank of captain after serving eighteen months with the American Expeditionary Force in France and England;

WHEREAS, Dr. Jelks returned to Jacksonville in 1919 to engage in the practice of general surgery, and that same year joined the Association, was married to Miss Isabelle Peyton Welch, the daughter of Dr. George E. Welch, a practicing physician in Putnam County for half a century, and began a brilliant career, filling many high posts of responsibility and receiving many honors which it would be superfluous to recount in detail here;

WHEREAS, This untiring servant of Medicine has given himself unstintingly in dedicated service to the Association, serving in its House of Delegates for many years since first representing the Duval County Medical



Society in 1930, the year after he had served as president of that component society, has served with distinction as President of the Association (1937), has participated repeatedly through the years as a member and often chairman of reference committees of the House of Delegates, notably those on Public Policy and on Health and Education, has rendered valuable service on various standing committees, including the Committee on Scientific Work, the Committee on Medical Economics and especially the Committee on Legislation and Public Policy, has headed the Committee on Medical Preparedness (1941) and the War Participation Committee during the World War II years, has with great credit served several terms as the Association's representative in the House of Delegates of the American Medical Association, and has served on the Board of Governors as Liaison on Public Relations since 1954 when the post was established; and

WHEREAS, This versatile representative of the Association has served as President of the Florida Medical Foundation since it was organized in 1956 and was a charter member of the board of directors of both Blue Cross and Blue Shield; Therefore, be it

RESOLVED, That the Association's first Certificate of Merit be awarded to Dr. Jelks, courtly gentleman of Medicine and exemplary member of this Association, in recognition of his outstanding ability, his unswerving loyalty, his complete dedication, his prodigal expenditure of time and talents at great personal sacrifice in the interests of the Association and of organized medicine as a whole, and his innumerable contributions to the art, the science and the socioeconomic progress of Medicine in Florida and in the nation.

Dr. White: "The resolution on health insurance at reduced rates for persons over 65, presented by the Broward County Medical Association—the committee endorses the principles contained in this resolution and recommends that it be referred to the Committee of 17 for study and recommendations.

"Mr. President, I move this portion of the report be adopted."

Seconded by Dr. Tolle.

Motion carried.

## Resolution

### Health Insurance for Persons Over 65

WHEREAS, through the great strides made in therapeutic and preventive medicine under the system of free enterprise many people are now living beyond the age of 65, and even beyond the proverbial age of three score years and ten, to enjoy the golden years of senior citizens, and

WHEREAS, some of these senior citizens have greatly reduced means during this period and are unable to provide for their own complete medical care, and

WHEREAS, it is the policy of organized medicine to provide medical care regardless of the financial status of the individual,

NOW THEREFORE BE IT RESOLVED, that the Florida Medical Association urge both Blue Cross & Blue Shield and all commercial health insurance companies to provide ways for continuing all contracts which are already in existence at age 65, and

BE IT FURTHER RESOLVED, that Florida Blue Shield be requested to study the feasibility of providing at reduced premiums medical and surgical coverage for those citizens over 65 with an income for a couple of \$3000.00, and for a single individual of \$2000.00, and that the physicians of Florida agree to accept one-half

the "A" schedule of Blue Shield benefits for these senior citizens who are in reduced financial circumstances. It is suggested that each year's application for this coverage be supported by a copy of the previous year's income tax report, and

BE IT FURTHER RESOLVED, that the Florida Hospital Association and the American Hospital Association be petitioned to provide Blue Cross coverage for senior citizens in these income brackets at reduced premium rates.

Miles J. Bielek, President

Broward County Medical Association

Dr. White: "The resolution on Essay Contest presented by the Dade County Medical Association is approved.

"Mr. President, I move the adoption of this portion of the report,"

Seconded by Dr. Mathers.

Motion carried.

## Resolution

### Essay Contest

WHEREAS, The Essay Contest for High School Students, sponsored by the Association of American Physicians and Surgeons (Titles: The Advantages of Private Medical Care or The Advantages of the American Free Enterprise System), and

WHEREAS, The need for such a contest seems to increase each year, and

WHEREAS, Such approval by the House of Delegates of the Florida Medical Association is essential for the sponsorship by the State and local Medical Auxiliaries,

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Florida Medical Association for 1959 go on record as approving this contest and recommending it to the Woman's Auxiliary for sponsorship.

R. Spencer Howell, M.D.

Dade County Medical Association

Dr. White: "With reference to the resolution on Free Choice of Physician, presented by the Florida Academy of General Practice, the committee believes the intention of this resolution has been sufficiently covered in the supplemental report of the Board of Governors, but wishes to reiterate its belief in the necessity of free choice of physician.

"Mr. President, I move this portion of the report be adopted."

Seconded by Dr. Collins.

Motion carried.

Dr. White: "I move the adoption of this entire report as amended."

Seconded by Dr. Collins.

Motion carried.

Dr. White: "I would like to thank the members of this committee, Drs. Ralph S. Sappenfield, James T. Cook Jr., Robert L. Tolle and H. Quillian Jones for their help and interest. I would also like to thank our efficient secretary, Miss June Palmer."



## Report of Reference Committee No. 4

### Legislation and Miscellaneous

Dr. Edward W. Cullipher: "Mr. President and Members of the House of Delegates: Your reference committee on Legislation and Miscellaneous gave careful consideration to items referred to it and makes the following report:

"The report of the Committee on Legislation and Public Policy and supplement—this report is approved as printed in the Handbook. The supplemental report is also approved, and we recommend to the House of Delegates that our stand of two years ago be reiterated in regard to the Relative Responsibility Law.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion seconded and carried.

### Report of Committee on Legislation and Public Policy

H. PHILLIP HAMPTON, *Chairman*

In the past year the activities of your Committee have been directed to formulation, promotion, securing and maintaining legislation considered to be in the best interest of public health and scientific medicine. During the year, and at the time of the reorganization of the executive office, there was established a separate department known as the Legislative Department. This department is under the direction of Mr. Alvin D. James, who devotes full time and attention to both national and state legislative affairs of the Association.

#### National Legislation

All requests received from the A.M.A. Committee on Legislation and the A.M.A. Washington Office, regarding legislative matters, were considered and complied with. The F.M.A. Key Contact Physicians are deserving of commendation for the exemplary spirit in which they responded when called upon for assistance on specific matters and the rendering of reports of contact with their responsible member of Congress.

It is recommended that our Association consider the adoption of some practical approach in establishing a definite position regarding further expansion of federal support or federal benefits to categorical groups of people and especially any expansion of the Old Age Survivors Insurance program to include medical service benefits.

#### State Legislation

A meeting of your Committee was held on Oct. 4, 1958 to consider all proposed legislation received from county medical societies, the Association's President, allied organizations, state officials, and the House of Delegates.

The report of the Committee regarding proposed legislation was presented with recommendations to the Board of Governors at the time of their meeting on Oct. 10-11, 1958. The Association's legislative program is to be presented to the Legislative Committees and officers of each county medical society urging them to explain the program to their legislators prior to the convening of the 1959 session of the Florida legislature.

Your Committee is pleased to report that the study undertaken by the Citizens Medical Committee on

Health, appointed by the Honorable LeRoy Collins, Governor, State of Florida, was completed and presented to the Governor. Those recommendations included as a part of the Governor's legislative program will receive the support of our Association. The Committee is most grateful for the experienced chairmanship of Edward R. Annis, M.D., of Miami, and for the active participation and work by each member of the committee.

As during past sessions of the legislature, an office will be maintained in Tallahassee during the entire session by the director of the Association's Legislative Department and an attorney retained by the Association. This office is for the convenience of the legislators and others who may seek information with regard to medicine, health and education, as they affect legislation for the protection and benefit of Florida citizens.

"Today's Health," the American Medical Association's health magazine for lay persons, was subscribed to for Florida's congressmen, the governor and members of his cabinet, and state legislators. Acknowledgments indicate, with gratitude, that the gift subscriptions are a valuable source of health information.

On behalf of the Committee, I offer our sincere expression of appreciation for the assistance rendered by the President, Secretary, other state Association officers, and members of the legislative committees of the county medical societies.

This being a year wherein many important measures vital to the interest of the health of the nation will be considered by both the United States Congress and our own state legislature, it is expected that a supplemental report outlining current legislative events will be submitted.

#### Supplement

In the past 10 years, the F.M.A. has made a positive approach to the problem of medical care for the indigent which has produced programs of notable success.

We have been motivated by the desire to continue the traditional interest of the medical profession in providing for the medical needs of indigents and by the knowledge that unwise governmental programs for indigent medical care may lead to the loss of freedoms essential to the provision of good medical care for all of the people.

One of the principles upon which we have based our recommendations has been that the smallest governmental unit should bear the maximum responsibility—financial and administrative—for programs of indigent medical care.

In the last session of the Florida legislature we successfully offered to the joint appropriations committee an alternate plan of providing hospital care for the indigent by using only state and county funds rather than the plan recommended by the State Welfare Board financed by only federal and state matching funds.

We have fulfilled the expectations of that program during this biennium, but the situation has changed in the Florida Legislature now in session. The State of Florida finds itself seriously short of funds, and the chairman of the Senate Appropriations Committee has announced his intention to introduce legislation authorizing the use of federal funds in the Hospitalization for the Indigent Program and thereby putting the program under the administration of the State Welfare Department. That federal funds will be used in the medical care of the indigent in this state is a foregone conclusion.

The State Welfare Board, against the advice of its medical advisory committee, embarked on the vendor program using federal and state funds to pay for drugs provided for the indigent. For the next biennium it has requested for this vendor drug program state and federal funds totaling 11 million dollars.

If we permit the program for medical care of the indigent to be administered in this state by the Welfare Board using only federal and state funds, the medical profession will have lost its voice in guiding these health programs involving the expenditure of some 20 million dollars and we will find ourselves far down this avenue of approach to total government medical care.

The Governor's Citizens Medical Committee on Health has made recommendations concerning medical care for the indigent which have been embodied in specific legislative amendments approved by the Board of Governors of the F.M.A. which proved a means of maintaining and expanding the progress we have made in good economical medical care programs for the indigent in this state and permitting the legislature as it chooses to use state and federal funds in financing the program, but maximum financial support will continue at the county level of government.

I ask your instructions to me as chairman of the Legislative Committee on two specific points:

1. In presentations to the Legislature, may I make suggestions concerning the expenditure of federal funds as well as state and county funds to provide medical care for the indigent?

2. Will you specifically and strongly support a bill now in the Florida Legislature authorizing all medical services and drugs furnished by the State Welfare Board to be purchased through the State Board of Health?

Dr. Cullipher: "The report of the Committee on Mental Health is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Mathers.

Motion carried.

## Report of Committee on Mental Health

SULLIVAN G. BEDELL, *Chairman*

The Committee on Nov. 15, 1958, sponsored a meeting of the representatives of state agencies closely related to the mental health field, including the Interim Committee of the State Legislature. Brief reports of recent achievements and of legislative plans were exchanged. Among those present were Senator Tom Adams and Mr. James E. Yonge of the Interim Legislative Committee on Mental Health; Drs. William D. Rogers, John T. Benbow, and Arnold H. Eichert of the Florida State Division of Mental Health; Drs. Wilson T. Sowder and Wayne Yeager of the Florida State Board of Health and also their Chief Psychologist, Melvin P. Reid, Ph.D.; Dr. Paul S. Jarrett of the Florida State Alcoholic Rehabilitation Program; Dr. C. H. Carter of Sunland Training Center; Dr. Peter F. Regan III, University of Florida College of Medicine; and Dr. Samuel G. Hibbs of the Florida Psychiatric Society. This has become an annual event and is thought to have been of value in assisting to coordinate mental health efforts in the state as well as enabling our Association to keep well informed.

Your chairman and Dr. W. M. C. Wilhoit represented the Florida Medical Association at the Fifth Annual Conference of Mental Health Representatives of State Medical Associations in Chicago Nov. 21 and 22, 1958. The following topics were discussed:

1. Emotional Block versus Brain Damage in the Diagnostic Categories of Mental Retardation or Mental Deficiency in School Children.
2. Communicability of Mental and Emotional Illness.
3. Education for Psychiatric Medicine.
4. The Joint Commission on Mental Illness and Health-Progress and Problems.
5. Mental Illness and Health in the Aged.

Also discussed were problems of relations between psychiatry and psychology. The discussion generally followed the line of the letter from the Florida Psychiatric

Society which your Committee approved last year and which each county medical society was asked by the Florida Medical Association to print in its bulletin. The Committee has under consideration plans for promoting a closer relationship with the county medical societies.

Dr. Cullipher: "The report of the Committee on State Controlled Medical Institutions and the resolution on Training Center for Retarded Children are approved as printed in the Handbook and were approved in conjunction as they deal with the same subject matter.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Tolle.

Motion carried.

## Report of Committee on State Controlled Medical Institutions

WILLIAM D. ROGERS, *Chairman*

As Chairman of the Committee on State Controlled Medical Institutions, I wish to submit the following report:

### Division of Mental Health

This Division has supervisory control of the following state institutions:

Florida State Hospital, Chattahoochee  
G. Pierce Wood Memorial Hospital, Arcadia  
South Florida State Hospital, Hollywood  
Northeast Florida State Hospital, Macclenny.

To emphasize the expanding needs in the field of mental health in Florida the admission rate for the past ten-year period was reviewed, and is listed as follows:

Total Admissions: Biennium 1951-53—3,743  
Biennium 1953-55—4,797  
Biennium 1955-57—6,125  
Biennium 1957-59—7,612  
Biennium 1959-61—9,045.

This marked increase in admissions is due, of course, to our rapid increase in state population, as well as educational programs in mental health, and to the fact that more and more people are relying on state hospitals for the treatment of psychiatric disorders.

The Florida State Hospital at Chattahoochee, being the largest of the state hospitals, is still having to receive the majority of admissions; however, the G. Pierce Wood Memorial Hospital, Arcadia, is accepting more patients each year and expanding treatment facilities to better serve that area.

The South Florida State Hospital at Hollywood has been in operation less than two years and presently is serving eight surrounding counties.

The Northeast Florida State Hospital at Macclenny is presently under construction, and plans are being developed to receive patients during the summer of 1959. This will furnish a badly needed facility and will help greatly in relieving the work load of the other institutions, especially at Chattahoochee.

Throughout all the hospitals early intensive treatment is being emphasized. The professional staffs are being expanded and more planning developed in the field of research. There has been a very definite improvement in the release rate, as well as length of stay of the patient.

With the close proximity of the South Florida State Hospital to the Medical School at the University of Miami, and the Northeast Florida State Hospital at Macclenny being reasonably close to the Medical College of the University of Florida, it is hoped that much cooperative effort can be obtained from the Medical Schools in research and training.



There has been some new construction in the mental hospitals during this biennium even though, due to the financial crisis of the state, many projects had to be placed in reserve. The South Florida State Hospital is just completing additional facilities, which will bring their total patient population to approximately 1,300. However, it is hoped that the two new hospitals, in Hollywood and at Maccleenny, will not exceed a patient population of 2,000 in their future size.

In the field of mental health, it has been encouraging to note the interest in general hospitals in providing psychiatric facilities in areas that would justify these facilities. It is definitely believed that this is a step forward to the patients for early treatment, and for those patients requiring only short term hospital care.

### **Division of Child Training**

The following institutions come under this Division:

Sunland Training Center, Gainesville

Sunland Training Center, Lee County

Sunland Training Center at Gainesville has continued to grow during the past year, and the population has reached just above 1,600. They are continuing to accept children as rapidly as they can, and the ultimate capacity will be approximately 2,100.

They have just completed, in the way of new construction, an addition to their laundry, and an addition which completes the Negro nursery and infirmary, giving them an additional 48 beds in that building. They still have under construction a new nursery building for children under six, which will accommodate 96. These beds are included in the total of 2,100 population. They also have under construction additions to their hospital and clinic, which include a new ward for Negro patients of some 26 or 28 beds, and what they refer to as a "research nursery wing." This they hope to use to bring in infants for study and research and will have about 24 beds. The Negro section of their clinic building is also being enlarged to accommodate the increased population.

During the year they have continued their usual programs of school and activity classes for trainable children, as well as occupational therapy for those who need such treatment. They have made considerable progress in the development of a section of vocational rehabilitation and training under the Training Department. They have a coordinator and an assistant in this department, as well as vocational counselors for both boys and girls. They have been working very closely with the State Vocational Rehabilitation Service and out of 22 referrals this past year they have been aided in placing at least eight of their boys and girls in some gainful occupation.

During this year they have also begun a program of physical therapy with a full-time therapist, and for a short while they had an assistant.

A new Chapel was dedicated in December, 1958, a full-time Chaplain has been employed and it is felt he is going to render a great service to their boys and girls in the development of a program of religious training and education.

The waiting list for admission to the Sunland Training Center at Gainesville now exceeds 1,000 and during 1958, 574 new applications were received, the largest number ever filed in one year.

To supplement the present facilities at the institution in Gainesville, the legislature appropriated funds for a new institution known as the Sunland Training Center, Lee County. This institution is presently under construction. It is anticipated that this appropriation will provide 780 beds in the new institution; however, it can readily be seen that these additional beds will not take care of the waiting list, for by the time this institution is ready to open many additional applications will have been received.

### **The Florida Alcoholic Rehabilitation Center, Avon Park**

During 1958 the Florida Alcoholic Rehabilitation Program has continued to develop its services along the three main lines of treatment, education and research.

Alcoholism is generally viewed by the Program as a socio-medical condition of an addictive type, characterized by a describable progression of symptoms and usually associated with other psychiatric difficulties. The condition is regarded as sufficiently widespread and complex in its involvements as to require a specialized program which integrates activities and disciplines in a unitary approach, the objectives of which are control and prevention of the condition.

Clinical services covering diagnosis, treatment, rehabilitation and referral are offered through four outpatient clinics located in Miami, Jacksonville, Tampa and Pensacola, and a 50 bed inpatient facility in Avon Park. These services are limited to residents of the State for at least one year who voluntarily request treatment.

Th outpatient clinics, limited to the ambulatory treatment of alcoholism, are headed by senior physicians who are also psychiatrists. Each clinic is staffed by full-time psychiatric social workers, part-time internist and psychologist, and full-time clerical personnel. Since the opening of the clinics in 1955, 1,844 individuals have been registered; 534 were registered in 1958. During 1958 plans were also initiated to open a limited service in Fort Lauderdale for alcoholic patients. It is expected that this service will be ready to accept patients early in 1959.

The Alcoholic Rehabilitation Center which opened on Dec. 3, 1956, has admitted 1,069 patients. There were 590 admissions and re-admissions in 1958. The Center provides medical care, psychiatric social work, and psychotherapy as a part of the rehabilitation of alcoholics. Twenty-eight days is the maximum period of hospitalization. Re-admissions are permitted for carefully selected patients. The state administrative offices of the Program are also housed in the Center.

During the past year, the state-wide educational activities of the Program have increased in scope. In April the Program sponsored, in cooperation with various other interested organizations, a state-wide conference on "The Problem Drinker in Industry" at the University of Florida. The General Extension Division of the University of Florida produced for the Program a film entitled "Challenge," which depicts the life history of an alcoholic and his treatment through the outpatient clinics and the Rehabilitation Center. This film is available to civic groups, county and state governmental groups.

In cooperation with the State Department of Education, the Program is planning a special project in alcohol education as a part of health education in the public schools. Other activities consist of speaking engagements, radio and television programs, distribution of films, community conferences, professional and in-service training, public meetings, distribution of printed materials, etc.

The Alcoholic Program has cooperated with (1) the Division of Vocational Rehabilitation in providing orientation to alcoholism as a part of its training for vocational rehabilitation counselors; (2) with the Florida State Board of Health in its uniform report of outpatient clinic statistics to the National Institute of Mental Health; (3) the Parole Commission in providing special training for its staff.

Research in the Program has been limited to a staff study of admission criteria and the effectiveness of certain types of treatment. The program is also cooperating in a five year "patient fate" study under the direction of the Yale Center of Alcohol Studies, New Haven, Conn., financed by the United States Public Health Service, Institute of Mental Health. The study is currently in operation at the Program's Miami Out-patient Clinic.

## **Resolution**

### **Training Center for Retarded Children**

WHEREAS, the present Sunland Training Center for retarded children in Gainesville is approximately 400 miles from Pensacola and is presently overcrowded;

WHEREAS, facilities presently under construction will still not be adequate to provide for retarded children in this area,



BE IT THEREFORE RESOLVED that a third such training center be constructed in Escambia County.

Respectfully submitted,  
Joseph Q. Perry, Secretary  
Escambia County Medical Society

Dr. Cullipher: "The report of the Poliomyelitis Medical Advisory Committee is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Collins.

Motion carried.

### **Report of Poliomyelitis Medical Advisory Committee**

RICHARD G. SKINNER JR., *Chairman*

During the past year the Committee sent a letter to all members of the Florida Academy of General Practice and the Florida Pediatric Society outlining the current polio situation in the state and urging increased immunization efforts through the county medical societies.

Assistance in developing and implementing programs was rendered county medical societies and other groups by the Committee and the Association's executive staff when called upon. Several societies carried out intensive immunization drives with gratifying results, which confirms the belief of this Committee that such programs should originate and be implemented at the local level with the guidance and assistance of the State Committee.

It has been demonstrated that the largest group of non or partially immunized people for polio or other diseases lies in the indigent and extremely apathetic groups and it is these groups which are relatively resistant to obtaining immunization voluntarily through educational efforts. The time has come when the members of the Florida Medical Association should face the possibility that some means of mass immunization, under the auspices of organized medicine, should be utilized to protect these specific groups.

Dr. Cullipher: "The report of the Committee on Aging is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Frank C. Bone.

Motion carried.

### **Report of Committee on Aging**

SAMUEL GERTMAN, *Chairman*

The F.M.A. Committee on Aging, although relatively a newcomer, may well turn out to be one of its busiest. The problems of the aged and the impact that these problems have had on medicine and medical practice are growing apace.

Before we could have our first committee meeting, Dr. Jere W. Annis asked the chairman of the Committee to represent the F.M.A. at the AMA Planning Conference on Health Problems of the Aged held at Chicago Sept. 13-14, 1958. Emphasis was placed on the complexity and urgency of the problem, and action was asked on a state and county level. A letter has been sent by the chairman to each county medical society secretary, asking them to consider the formation of a local committee on the aged. For our work to be effective in meeting the health problems of the aged, physicians must, as recommended by the AMA, get to work on a grass roots level, and promptly.

Our Committee next participated in the First Governor's Conference on Aging of the State of Florida in

Tallahassee, Nov. 20, 1958. Our Committee members were largely responsible for the development of the medical portion of the program, and were active participants in the panel discussions.

At the request of the Committee, the Board of Governors joined the Florida Council on Aging as a contributing member. The First Governor's Conference on Aging was held under the auspices of the Florida Council on Aging. In this way the F.M.A. is in the position of supporting the other community forces organized for meeting the problems of the aged, as well as insuring for itself a voice in the next Governor's Conference and in the White House Conference on Aging to be held in 1961.

The Committee has also been requested by President Annis to look into the problems of the economic aspects of health needs of the aged of the state of Florida. This project would have a double purpose, one to help develop programs that would better meet the needs of the aged; the other to develop data that would help the medical profession in its efforts to remain as free of government entanglements as far as possible. This is pertinent to the work of our Committee as the health needs of the aged are being used as the entering wedge by those interested in establishing government control of medical services.

A joint committee has been formed by a union of the Research Committee on Aging of the Florida Blue Shield and the F.M.A. Committee on Aging in order to pursue these projects. A preliminary conference was authorized and has been held in an effort to sketch out the dimensions of the projects to be studied. One of these is for the Florida Blue Shield to develop, with the aid of the F.M.A., a reduced cost health insurance policy for the medically indigent aged. Still another aspect of this work will be to project social and economic trends and how they might affect medical care for the aged and medical practice in the years ahead.

The work of the committee is being financed at present by the Florida Blue Shield. As projects come closer to reality, other sources of funds will be needed to carry them out.

We look forward to a busy year.

Dr. Cullipher: "The report of Delegates to the American Medical Association is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Tolle.

Motion carried.

### **Report of Delegates To American Medical Association**

Louis M. Orr, M.D.  
Reuben B. Chrisman Jr., M.D.  
Francis T. Holland, M.D.

Summaries of the June and December 1958 meetings will be found in the September and March issues of The Journal of the Florida Medical Association. A summary of the June meeting was forwarded to every member of the Association by our President and the summary of the December meeting was provided every physician in "The AMA News."

The AMA delegates would like to invite every Florida physician to visit the business sessions of the AMA House of Delegates in Atlantic City this June and Dallas next December.

We also wish to remind Florida physicians that the 1960 Annual Meeting of the AMA will be held in Florida at Miami Beach on June 13 through 17 next year. We hope Floridians will start now to make plans to attend.

Dr. Cullipher: "The report of the Florida State Board of Medical Examiners is approved

in principle, and we recommend that it be referred to the Committee on Legislation and Public Policy and other appropriate committees of the Florida Medical Association. It is further recommended that this Committee, in consultation with the State Board of Medical Examiners, after thorough investigation and study, prepare a satisfactory Medical Practice Act to be presented to the House of Delegates at its next meeting.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

**Report To: Florida Medical Association  
House of Delegates**

**FROM: Florida State Board of Medical  
Examiners, Homer L. Pearson Jr., M.D.,  
Secretary**

Since our last report to you we have examined for licensure 575 doctors; of these 114 failed, and 461 were issued licenses. We have suspended six licenses, placed seven doctors on probation, and two cases have been continued. One suspension ended and the doctor was reinstated.

The Division of Physical Therapy registered 39 physical therapists through endorsement and two through examination.

The last meeting of this House of Delegates gave their approval to the re-writing of the Medical Practice Act. Little progress has been made to date due to the fact that it was felt to be unwise to introduce medical legislation in the current session of the Legislature. Be that as it may there has been discussion at the Board meetings relative to certain desired changes.

On February 19, 1959, Dr. Robert Spicer, Dr. Ralph Jack, Mr. John Hanni of the Dade County Medical Association, Mr. Harold Parham and Mr. Al James of the Florida Medical Association, met in my office for the purpose of discussing the proposed revision of the Medical Practice Act.

The following proposed changes were made at this meeting:

1. That the purpose of the Board of Medical Examiners be not only to examine and license physicians but also to enforce the Medical Practice Act.

2. The Florida Medical Association is proposing a change in their constitution and by-laws to provide for the organization of a disciplinary committee, composed of two licensed doctors of medicine from each congressional district, elected by the House of Delegates. They want the Board of Medical Examiners to deputize the members of the committee as investigators for the Board. Further, as deputies of the Board they would be paid per diem and travel expenses while making investigations.

3. That the Board employ private legal counsel rather than depend upon the Attorney General's office.

4. Annual registration fee of \$10 for resident physicians to be paid to the Board of Medical Examiners. Annual registration of \$50 for non-resident physicians with a provision for exemption in cases of hardship.

5. Revocation of a license if licensee is not practicing in Florida within ten years.

6. In addition to the present requirements for examination add one year of approved internship or at least five years of private practice.

7. Semi-annual registration with the Board of Medical Examiners, instead of the State Board of Health, by the hospitals of interns and residents in training in their institutions. Training programs of the hospitals must be approved by the Board.

8. Exempt physicians employed in state institutions for a period of three years provided these physicians are qualified for licensure and are working under the supervision of a licensed medical doctor. They must be registered with the Board of Medical Examiners as provided in paragraph seven.

9. Accept persons for licensure through endorsement providing the applicant has successfully passed the examination for a license to practice medicine in all its branches in any other state of the United States; and, providing that examination was, in the opinion of the Board, equivalent in every respect to the examination given in this state; and, providing the examination was passed within five years of the date of filing application. Applicant must have a basic science certificate. Fee \$100.

10. Executive director or executive secretary, preferably a doctor of medicine, to be employed by the Board but who is not a member of the Board. When and if practical the executive offices of the Board of Medical Examiners be located in the headquarters building of the Florida Medical Association.

11. These proposals to be embodied in the general revision of the Medical Practice Act which will be left to the discretion of the Board of Medical Examiners and the Committee on Legislation.

These proposals have been circulated to the members of the Board. Some of them disagree with the idea of employing other legal counsel, some disagree with the idea of licensure by endorsement, two disagree with the requirement of an internship, and one disagrees with the idea of an executive secretary.

Dr. Robert Spicer submitted the following statement, with which I agree, and which should be included in this report:

"Presentation of proposals as submitted seem premature in my opinion, insofar as consideration and action of the Florida Medical Association House of Delegates at its imminent meeting is concerned; certain points are noted:

1. Our present Medical Practice Act can be reasonably criticized.

2. The number of desirable changes indicate the wisdom of complete redraft of the Act.

3. A number of proposed changes are controversial and essentially concern doctors of medicine only.

4. The practice of medicine in Florida is merely ONE of the "healing arts."

5. Within the past 30 years, the State Board of Medical Examiners began an initial attempt to solve problems which are still with us. The then new composite board amalgamated the Allopaths, the Homeopaths and the Eclectics—a then daring union which involved wide and sore concern.

6. Within the past two years the scope of our present Board of Medical Examiners has been increased by jurisdiction over the licensing of physical therapists, in fact a related healing art.

7. Within the past two years psychologists, who practice both diagnosis and therapy, including hypnosis which is now recognized as an instrument or technique of medical practice, have acquired a separate autonomy in no way affiliated with the Board of Medical Examiners.

8. The Florida basic science examinations have screened out a number of "healing arts" such as naturopathy, but not well-trained osteopaths who in fact have all the rights and privileges of doctors of medicine in this state:

- a. Since examinations in the basic science subjects are separately administered and apply to applicants for practice of all healing arts, said basic science subjects are neglectfully not integrated with clinical subjects, as would be proper and desirable.

- b. The principal effect of the basic science examinations at the present is an added, separate and unnecessary hurdle for well-grounded practitioners of medicine and osteopathy.



9. To protect and to improve the public health and welfare, a single examining and licensing board for ALL—repeat ALL—practitioners of the healing arts in Florida is obviously desirable.

a. Practitioners with equal rights and privileges should pass the same examinations.

b. Practitioners with limited rights and privileges, such as psychologists and physical therapists, should have appropriate special examinations and should continue to be subject to the single examining and licensing board, possibly via subordinate boards, with respect to authorized practice.

10. Associations of practitioners of respective healing arts and specialties should actively supervise, and if necessary, discipline their own members. But in any case, such associations should provide effective liaison to cooperate in matters which should come to the attention of the single examining and licensing board for the healing arts.

11. Annual registration fees, as well as initial fees for examinations for licensure, should be paid annually in sufficient amount to the Board to support its routine functions more broadly than in the past. When necessary, proper exercise of functions may require the employment of investigators, counsel (in addition to, or in place of, that provided by the Attorney General), and other assistants or agents to facilitate adequate and prompt attention to all appropriate functions of such authority.

12. Obviously such an overall program and its integral parts require exhaustive study and mature judgments. Qualified committees should advise and consult with the Board of Medical Examiners to develop FIRST, the best objectives and SECONDLY, the best form of legal stipulations for presentation to the next meeting of the Legislature.

Even with two years until the next meeting of the Legislature, study and determinations must be prompt to allow time for preliminary legal draft of the new Medical Practice Act, followed by review, re-study and possible redrafts prior to submission to the floor of the House of Delegates of the Florida Medical Association and others before an essential educational program to assure its legislative enactment."

It has been expressed by some that the executive secretary would not of necessity be a medical doctor and that ultimately the offices of the Board of Medical Examiners should be placed in the building of the Florida Medical Association and should use the same firm of attorneys as the Association. Some of us are not in agreement with this for we are sure it would be dangerous to have the Board of Medical Examiners integrated with the Florida Medical Association and subject to it.

Dr. Cullipher: "We recommend that the resolution on Social Security for physicians be disapproved. A poll on this subject has been taken of the members of the Florida Medical Association and the final analysis showed that the majority of the membership did not respond. It is also recommended that further study along this line be done at the county level with special emphasis and explanation of the Keogh type legislation. The general consensus is that to include physicians under a social security act would greatly diminish the possibility of the passing of a Keogh type legislation.

"Mr. President, I move that this portion of the report not be approved and not be published in The Journal."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Dr. Cullipher: "We recommend that the resolution on Selection of Physicians Participating in Rehabilitation Program be disapproved.

"Mr. President, I move that this portion of the report not be approved and not be published in The Journal."

Seconded by Dr. Steward.

Motion carried.

Dr. Cullipher: "The resolution on Physician Membership of Boards, Commissions, and Advisory Committees is approved.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

## Resolution

### Physician Membership of Boards, Commissions, and Advisory Committees

WHEREAS, It has become a common practice in the State of Florida, when medical service is to be furnished by governmental agencies, for an Advisory Board or Commission to be formed whose duty is usually to formulate medical policies for such services; and

WHEREAS, Such Boards or Commissions are usually appointed by the Governor upon the recommendation of the Florida Medical Association; and

WHEREAS, It is also a common practice for such Boards or Commissions to be almost exclusively composed of doctors certified by various Specialty Boards; and

WHEREAS, It is almost invariably true that these appointed Boards or Commissions select the physicians to implement their respective programs, and those physicians are almost exclusively diplomates of the various Specialty Boards; and

WHEREAS, This manner of selection is an arbitrary, albeit easy, criterion of competence; and partially implies by exclusion that all doctors not so certified are incompetent to perform these services, although in many instances they are daily performing such services; now

#### THEREFORE BE IT RESOLVED:

1. That the Florida Medical Association wishes to affirm its faith in the doctors of this State and believes they are ethical and competent doctors, cognizant of both their abilities and limitations and unwilling to attempt procedures beyond their competence, whether or not certified by a Specialty Board.

2. That the Florida Medical Association strongly recommends to those agencies appointing members of such Boards or Commissions that a much larger and more representative portion of these Boards or Commissions be general practitioners and non-certified specialists.

3. That the Florida Medical Association discourages and deplores any legislation calculated to limit the care of patients to Board certified specialists.

4. That the Florida Medical Association strongly urges the present and future members of such Boards or Commissions to adopt other criteria in addition to Board certification in choosing which doctors may serve for them; that they take due cognizance of the fact that surgical and medical competence are not limited to diplomates of Specialty Boards; and that the ethical physician will continue to refer to the specialists those patients for whom he is unable to adequately care.

Respectfully submitted,  
Glenn E. Padgett, President  
Jackson-Calhoun County Medical Society



Dr. Cullipher: "No action was taken on the resolutions on Privileged Communications and Medical Practice Act—Interns and Residents. It is recommended that these resolutions be referred to the Committee on Legislation and Public Policy as part of their study concerning the proposed revision of the Medical Practice Act.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

## Resolution

### Privileged Communications

WHEREAS, The Principles of Medical Ethics of the American Medical Association uphold the confidential relationship between the physician and his patients, and

WHEREAS, This confidential relationship is protected by law in all but seventeen of the United States, Florida being one of the exceptions,

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Florida Medical Association be requested to instruct the Florida Medical Association to seek the enactment of legislation safeguarding the confidential relationship between physician and patient in the State of Florida at the earliest opportune moment.

Respectfully submitted,  
DeWitt C. Daughtry, Secretary  
Dade County Medical Association

## Resolution

### Medical Practice Act—Interns & Residents

WHEREAS, There is no definition or duties described in our Medical Practice Acts concerning resident physicians, assistant resident physicians or interns serving in the hospitals of Florida;

WHEREAS, For the lack of a clear definition as to the duties and limitations of those serving in the capacity of resident physicians, assistant resident physicians or interns, there exists a great deal of confusion in the medical profession of the State;

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Florida Medical Association instruct its Committee on Legislation and Public Policy to draft and have introduced in the present session, or the earliest possible session, of the Florida Legislature an amendment to Section 458.13 of Chapter 458 of the Florida Medical Practice Act, giving an interpretation and its application of the duties and limitations of resident physicians, assistant resident physicians and interns serving in the hospitals of Florida, and to outline requirements for institutions with residency programs to insure that they provide adequate training.

BE IT FURTHER RESOLVED, That such amendment, prior to its introduction in the Florida Legislature, shall be approved by the Board of Governors of the Florida Medical Association at one of its regular or special meetings.

Respectfully submitted,  
Collin F. Baker Jr., Secretary  
Hillsborough County Medical Association

Dr. Cullipher: "Mr. President, I move the adoption of this entire report as amended."

Seconded by Dr. Collins.

Motion carried.

## Report of Reference Committee No. 5

### Charter and By-Laws

Dr. Francis T. Holland: "Mr. President and Members of the House of Delegates: It has been recognized for more than 10 years by the Board of Governors and the Managing Director that a revision of the Constitution and By-Laws was needed, and your Board of Governors has had a special committee which spent over two years in the preparation of this proposed Charter and By-Laws. Since any action taken by this House will not become final until it has been ratified by three-fourths of the component county medical societies, your reference committee does not believe that it could be improved by postponing this for any further study.

"The first of this year the proposed Charter and By-Laws was sent to all county medical societies for study. This document had been studied by legal counsel, who advised that it is in proper legal form.

"It should be pointed out that any changes made by the reference committee or by this House

of Delegates must be approved by legal counsel before they can go into effect. In other words, any changes approved must be subject to editing by our attorney, who, of course, would make only changes necessary to conform to proper terminology, Florida Statutes and Internal Revenue Code, and will not change the intent.

"Your reference committee considered the Charter and By-Laws and all resolutions and suggestions, paragraph by paragraph, and will report only on the changes recommended.

"There was much discussion, pro and con, on the matter of a Speaker of the House of Delegates, contained on page 5, Chapter VI, Section 7, and whether or not one is needed in our organization. It is the opinion of the immediate past president and the present president that this association is ready for this step. Since you believed these men were capable of directing your affairs for the past two years, your committee believes they are the most competent individuals to judge the necessity for this step.

"Reference Committee No. 5 unanimously recommends the following changes to the proposed Charter and By-Laws:

"Page 5, Chapter VI, Section 7, be changed to read:

"The Speaker of the House of Delegates *shall be elected by the House of Delegates from its membership* and shall preside over all meetings of the House and shall determine the number and times it shall convene during any one meeting. In consultation with the President he shall appoint a credentials committee and all reference committees and shall designate the chairman of each. It is the responsibility of the President to provide a presiding officer for the House of Delegates in the event the Speaker is unable to serve and a Vice Speaker is unavailable. *The Speaker of the House of Delegates may be elected to succeed himself only once.*

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herz.

Dr. Evans: "Mr. President, I am placed in a rather embarrassing position because after Dr. Holland's fine words, I wish to make a motion in the interest of time right now rather than after we have gone through the whole report. I think everybody realizes that this new Charter is the result of long study, but there has been a lot of criticism over the fact that while those who wrote it know a lot about it, the county societies know nothing about it. Certainly, not the membership and we believe it is not fair to take a step of this importance at this meeting of the House of Delegates. In spite of the fact that we realize much work has gone into it, we believe that it should be reconsidered. As Chairman of the Dade delegation, I wish to move for the delegation that the entire consideration of this matter be postponed for a definite time, namely, until the next meeting of the House of Delegates, for the purpose of having the entire Charter and By-Laws printed in The Journal so every member will have an opportunity to read it and we propose that the recommendations of the Reference Committee also be published with the Charter as now printed. I so move."

Seconded by Dr. David R. Murphey, Jr.

Dr. Annis: "That takes precedence over Dr. Holland's motion and is subject to limited debate."

Dr. Evans: "May I discuss my motion? We recognize that it will have to go to the county societies for ratification, but in spite of that, we be-

lieve it should be published so that every member will have a chance to read it; if he does not, there could be no criticism. The attitude of my delegation is that the need is not pressing."

Dr. Sackett: "The Dade County Medical Association has no ulterior motives in postponing this."

Dr. Tolle: "May I suggest that the same thing is being required because each component society must approve before it becomes effective?"

Dr. Borland: "Is there a reason for Section 7?"

Dr. Annis: "That is not germane to the motion."

Dr. Herz: "In opposition to the largest county society, the smallest county society can see no reason to postpone. This has been considered by our medical society, and I presume there are others who have studied it. A committee has spent two years on this matter, and I see no reason why we should postpone action for another year."

Dr. Marion W. Hester: "As pointed out, this was sent to every county society in January. It was certainly considered by Polk. Recommendations have been brought to the Board of Governors since then and many of them have been incorporated. We have spent two days listening to objections and have answered many of them. It will have to be ratified by three-fourths of the county societies before it can be effective. If there is something in it that you don't like, it can be easily amended."

Dr. Hester read the section on amendments.

Dr. Marion: "I would like to support what Dr. Evans said, and clarify that the work of this committee is not to be discarded; it is to be published so it may be read."

Dr. Zellner: "There is something holy about the status quo. I would say that less than 5 per cent of us know anything about the present Charter. This has been in our hands for four months and there is no guarantee that the same people who do not attend meetings are going to reform and give perfect attendance so they can learn about it. If we postpone it until the last member who might offer criticism has read it, we will not get anything done. This has been evaluated by more than one county society. It seems to me it would be better to adopt this and send it to the county societies for ratification and make any necessary changes next year."

Dr. Day: "I would like to point out that five or six county societies are waiting for this to revise their own Constitutions and By-Laws."

Dr. Anthony C. Galluccio: "I would like to say that Broward County has considered this very carefully. Initially I agreed with Dr. Evans that this should be postponed, but now I believe the House of Delegates is ready to consider it."

Dr. Annis: "We will now vote on Dr. Evans' motion to postpone."

Motion lost.

Dr. Collins: "In this section, while I agree that we need a Speaker, I think it should be the prerogative of the President to appoint his own committees. I move that we change it to read that committees shall be appointed by the President in consultation with the Speaker. I am referring to the appointment of the Credentials Committee and Reference Committees."

Seconded by Dr. Tolle.

Motion carried.

Dr. Holland: "I move that we approve this portion of the report as amended."

Motion seconded and carried.

Dr. Holland: "Page 5, Chapter VI, Section 8. Add to this section the following sentence: *The Vice Speaker of the House of Delegates may be elected to succeed himself only once.*"

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Holland: "Page 6, Chapter VII, Section 2, paragraph 8, be changed to read: 'The Board of Governors shall divide the state into *not less than* four medical districts *based insofar as feasible on physician population* and shall define their boundaries."

"Mr. President, I move the adoption of this portion of the report."

Motion seconded.

Dr. Zellner: "Does this mean that the Broward County resolution was disapproved?"

Dr. Holland: "Yes, it does."

Motion carried.

Dr. Holland: "Page 8, Chapter IX, Section 2, be changed by adding an additional paragraph 13 to read:

*"13. Advisory Committee to Blue Shield—shall be composed of seventeen members, consisting of a chairman and sixteen members, four from each Medical District, appointed by the President with staggered terms. The various fields of medicine shall be represented.*

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herz.

Motion carried.

Dr. Holland: "Page 10, Chapter XI, Section 3, paragraph 4, second sentence be changed to read:

"No member may hold simultaneous membership, *other than honorary*, in more than one county medical society."

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Holland: "Your reference committee unanimously recommends that the proposed Charter and By-Laws, as amended, be adopted as the Charter and By-Laws of the Florida Medical Association."

Seconded by Dr. Tolle.

Dr. Cecil M. Peek: "Just a point of information. In the matter of a physician holding simultaneous membership, does that say honorary or probationary?"

Dr. Roberts: "Isn't a probationary member an applicant rather than a member?"

Dr. Hester: "Other ways of stating this were considered. Dr. Peek's suggestion would create the situation of having probationary members in two county societies which we do not want."

Dr. Peek: "I move that we change it to: 'No member may hold simultaneous active membership in more than one county medical society'."

Motion seconded.

Dr. Hester: "That was what I suggested at first, but it was pointed out that this does not take care of it."

Dr. Holland: "The reason for this was that in some counties where a physician lives on the border, he might have honorary membership in another society which would give him hospital privileges."

The Chair called for a voice vote which was inconclusive.

On a show of hands, the amendment carried.

Dr. Steward: "Before we adopt it as a whole, there is one point I would like to amend. I am surprised that Broward County hasn't called this to your attention. The Board of Governors is more and more having to transact business. When a governing board is appointed, it is not necessarily a representative board. Therefore, the resolution by Broward County which was passed over in the recommendations of the Reference Com-



mittee should be considered. It leaves a situation where the President appoints the members of the Board of Governors. I would like to move that we amend the Charter and By-Laws, Chapter 7, Board of Governors—Composition, 'and five members to be elected by the House of Delegates'."

Seconded by Dr. Collins.

Dr. Tolle: "It should be added that when more medical districts are created, there should be one from each district."

Dr. Borland: "Is it the intention that these would be nominated by the districts?"

Dr. Annis: "That is not in the motion; apparently they could be nominated by anyone."

Dr. Galluccio: "I would like to make a comment which I have already made to Dr. Holland and this is said as constructive criticism. Dr. Holland ran a very beautiful session. I do believe that when a resolution is presented and considered at a reference committee, and a question comes up relative to that point, the one who first proposed the change should be given first crack at it."

Dr. Annis: "I will have to rule that is out of order."

Dr. Holland: "You elect your President, and he has the responsibility for running your organization. It is true that it is getting to be big business and we should have representation. However, if someone is elected who is not friendly to your President, you may have turmoil on your Board. Your President can appoint only one man from one district and one at large. We feel you owe it to your President to give him some authority. If you adopt this, the office of President is merely being that of a general flunky and not running the affairs of the Association."

Dr. Walter C. Jones: "At our meeting Monday morning, the Board of Past Presidents discussed this and those of us who came up through the Association through a period of years can remember when the President went in without having any power to appoint anybody. Every President has one or two men he would like to help him. It is possible the House of Delegates might elect such a man, but they might not. It is only fair to the man you elect as President to permit him to appoint one or two men to help him."

Dr. Evans: "This comes in support of Dr. Holland. The districts are composed of many county societies, and that would pose quite a problem in electing a member to the Board of Governors. We always felt that judges should be elected. There has been a very definite trend the

other way to allow the chief executive to appoint judges because it was believed better judges can be selected by appointment than by election. I think the president is in better position to know which men are good men, who will be willing to work and will serve him better than men who are elected for political reasons."

A vote was taken, and the amendment lost.

Dr. Holland moved for adoption of the report as a whole.

Dr. Annis: "The amendment has lost, and we now have before us the question of adopting the report on Charter and By-Laws as a whole."

Dr. J. Raymond Graves: "Dade County delegation caucused this morning, and I am still of the opinion that we should not adopt it until it has had further study."

Motion carried.

(The Charter and By-Laws appear at the end of these Proceedings.)

Dr. Holland: "Mr. President, your committee wishes to thank all of the members of the Association who appeared before us and gave us valuable assistance in arriving at the above conclusions.

"I wish to thank the individual members of the committee for the time and effort spent in the preparation of this report. This report is signed by Drs. Floyd K. Hurt, L. Washington Dowlen, Marion W. Hester, Madison R. Pope and Francis T. Holland, Chairman."

Dr. Annis: "Thanks to every one of you on the reference committees for the fine work you have done."

"Is there any unfinished business? If not, the Chair will entertain a motion that we suspend the rules so that we can proceed with the election of officers."

Dr. Peek moved that the rules be suspended. Motion seconded and carried.

Dr. Annis: "We will receive nominations for the office of President-Elect."

Dr. Marion: "I wish to thank my friends for the privilege of nominating our President-Elect. These remarks are altogether unnecessary for many of you, for you have enjoyed the experience of working with him on many local, state and national problems, sharing his enthusiasm, good sense and generosity for many years. These remarks are especially superfluous for the fortunate few who count themselves his devoted friends.

"For the rest, however, I will try, within the few minutes permitted by our crowded schedule, to sketch the outline of a man in traditional and

Biblical fashion. 'By his works, ye shall know him.'

"This man was born in Savannah. He received his academic degrees from Emory and Jefferson. First and foremost in the list of blessings for which he gives thanks to his Creator is his devoted family; his lovely wife, the former Helen Ross Dixon, and his two fine sons, Michael and John. He is an elder in the Presbyterian Church. He has served as vice president of the Florida Junior Chamber of Commerce, and is a member of the Jacksonville Chamber of Commerce. He has served the Jacksonville Community Chest in a variety of assignments during the years, and is a member of the board of trustees of the Bolles School. He received his postgraduate training in medicine at St. Vincent's Hospital in Jacksonville, later rising to the positions of president of the staff and chief of the Department of General Practice in that institution. He has practiced medicine in Jacksonville for 19 years. He has served the Duval County Medical Society as its president. He has been president of the Florida Academy of General Practice. At this time he is serving the American Academy of General Practice as a member of its Commission on Hospitals. He has served Blue Shield of Florida for three years as a member of its board of directors and as a member of its executive committee. He is a district chairman of the Florida Committee for Better Government. All of the recent past presidents of the Florida Medical Association will gladly testify that this man helped them in their difficult and demanding work more than most of us. He has been a working member of many of our more important committees. He served for two years as one of our legislative key contact physicians, having journeyed twice to Washington to meet with and advise our legislators. For three years he has served on the reference committees at our annual meetings while most of us slipped away to enjoy our carefree holiday. He has been Councilor for his District for the past two years. I submit my belief that no one is more familiar with the hard work required by this job than the man I have so briefly described to you, and my equally sincere belief that no man among us is less frightened by it or more capable of coping with it, courageously, efficiently and effectively.

"I am honored to be permitted to nominate Leo M. Wachtel."

The nomination was seconded by Dr. Rowland E. Wood of Pinellas, Dr. Ashbel C. Williams of

Duval, Dr. Fred Mathers of Orange, Dr. William C. Roberts of Bay.

Dr. Galluccio: "We of Broward County heartily endorse Dr. Wachtel as our President-Elect and move that nominations be closed and the Secretary be authorized to cast the ballot for Dr. Wachtel."

Seconded by a chorus of voices.

Motion carried.

Dr. Annis asked Dr. Frederick H. Bowen and Dr. Henry J. Babers Jr. to escort Dr. Wachtel to the rostrum.

Dr. Annis: "The reason we do this is to let you see how well he looks before he starts."

Dr. Wachtel: "President Annis, Members of the House of Delegates, Members of the Florida Medical Association:

"I thank you for all 'them kind words.' Dr. Marion really 'painted me up' to say that I was without fear, for that is certainly not the truth.

"I am not unmindful of the responsibility and challenge that go with this job. The challenge is great in view of the giants of medicine in Florida who have preceded me. I am humble in the face of the fact that there are many fine men who would probably do a better job than I, but I will do my best. In closing, my only further remark is a comment made by a man giving a lecture on sex—it gives me great pleasure."

The Chair asked for nominations for the office of First Vice President.

Dr. Cullipher: "Mr. President, Members of the House Delegates: I have not prepared a paper about my candidate, which with a change of title could be used as an obituary, but he has been a member of the Association since 1928. The man I propose to you is Dr. Eugene B. Maxwell of Tampa. I am sure you all remember the excellent job he did as Chairman of the Public Relations Committee when it was a 'hot potato'. He has also worked on many committees, but has never been an officer. I must admit he is not perfect. You will remember he was unwise enough to move from Miami to Tampa. I would like to place in nomination for First Vice President the name of Dr. Eugene B. Maxwell of Tampa."

Dr. Murphey: "I want to endorse what Dr. Cullipher has said about Dr. Maxwell, and our county is delighted to endorse his nomination. It was during my term as president that Dr. Maxwell did such a magnificent job as Chairman of the Public Relations Committee. Since that time he has served this Association whenever he was called on."



Dr. Tolle moved that the nominations be closed and the Secretary cast the ballot for Dr. Maxwell.

Motion seconded and carried.

The Chair requested nominations for Second Vice President.

Dr. Eugene G. Peek Jr.: "I would like to nominate for Second Vice President of the Florida Medical Association a past president of the Florida Academy of General Practice, Dr. Henry L. Harrell, of Ocala."

Dr. Mathers moved that nominations be closed and the Secretary cast the ballot for Dr. Harrell.

Motion seconded and carried.

Dr. Annis asked for nominations for Third Vice President.

Dr. Willard F. Ande: "I would like to place in nomination the name of Dr. Ralph M. Overstreet Jr."

Dr. Mathers moved that nominations be closed and the Secretary asked to cast the ballot for Dr. Overstreet.

Seconded by Dr. Steward.

Motion carried.

The three Vice Presidents were asked to come to the rostrum for a photograph.

Dr. Annis: "Nominations are in order for Secretary-Treasurer."

Dr. Zellner: "This should be a eulogy instead of a nomination, and I refer to my friend, Sam Day. His accomplishments need no recounting here since they are well known to most of you. Suffice it to say that he is an honor to the position which he holds, and I am proud to place his name in nomination for Secretary-Treasurer of the Association."

Dr. Carson: "I would like to rise to a point of order and suggest that the President relinquish the Chair and assume his prerogative of nominating the Secretary-Treasurer. Seriously, I move the nominations be closed and that Dr. Samuel M. Day be elected the Secretary-Treasurer."

Motion seconded and carried.

Dr. Annis: "Certainly we are all indebted to Dr. Day for the work he has done.

"And now gentlemen, it is with considerable relief and yet with some little regret, for you have been very kind to me, all of you, this past year, that I give this gavel and all the duties and responsibilities that go with it to your new President. It is, Ralph, far heavier than it looks. Yet I know it will be your prized possession and you

will administer the duties of the office which it represents with all the courage, industry and integrity which have characterized your service to this Association for the past many years. I speak for everyone here when I say that we are not only content, we are proud to have you as our representative and official spokesman. May God prosper your tenure of office and may the members of this assembly counsel and sustain you as they have me. Ladies and gentlemen, I give you the President of the Florida Medical Association. Dr. Jack."

Dr. S. Carnes Harvard and Dr. Ralph S. Sappenfield escorted Dr. Jack to the rostrum.

Dr. Annis presented to Dr. Jack a gavel engraved with his name and year of service.

Dr. Jack: "Dr. Annis, Members of the House of Delegates and other members of the Florida Medical Association and Guests:

"I accept this gavel with a feeling of profound humility mixed with the emotions of anticipation. I hope with you that I shall wield it well and always for the best interests of the Florida Medical Association and the public we serve.

"It was Dr. Francis Langley who said, 'One cannot prepare for a moment like this.' From both past and present experience I know how correct he was in that statement. When I was in college, I was on the rowing team. Believe it or not, I was a slightly built individual, certainly not of the stature to pull a strong oar. My position as coxswain was to steer the boat or shell. If we won a race, those big fellows built like Dave Murphey or Duncan McEwan would pick me up and throw me in the water. It was sink or swim.

"You have reversed the procedure a bit on me. You threw me in last year when you elected me to be your President. You have given me a year under most excellent coaching to find my seat in the boat. I hope to steer us to a victory. I know it will not be an easy year for our problems will be many. If all of you will pull at your individual oars in complete unison and harmony, it will not be too difficult. I promised you last year that I would do my best; I repeat that pledge today. Thank you for your confidence and for bestowing upon me your highest honor.

"By making me your President today, you have awarded me the privilege of performing several especially pleasurable duties. We all fully realize the exceptional job done for all of us by our immediate Past President—Jere Annis. It is with great pride that I present this Past President's Button and Certificate of Honor to him.



"Jere, wear this button and keep this certificate through all the years to come with the knowledge that you have earned them and our everlasting gratitude.

"At this time I would like to ask Dr. Charles Larsen, of Lakeland, to escort Mrs. Annis to the front of the hall.

"Mrs. Annis, this is a new tradition and a very special honor for me to present to you on behalf of the Florida Medical Association this portrait of Dr. Annis which has adorned our Board Room in the offices of the Florida Medical Association for this past year. We hope you will cherish it and thank you for the loan of that wonderful man for the past year."

The members of the Assembly stood and applauded as Mrs. Annis took the portrait.

Dr. Jack: "A little earlier, during the report of the reference committees, you heard me request a very special privilege. This is the first time any President of the Florida Medical Association has had this honor, and I do indeed consider it an honor. I would like to request Dr. Louis Orr and Dr. Homer Pearson to escort Dr. Edward Jelks to the front."

Again the members of the House stood and applauded, as Dr. Jack presented to Dr. Jelks the first Certificate of Merit.

Dr. Jack: "It is a very special honor to me to have the privilege of presenting the very first Certificate of Merit ever awarded by the Florida Medical Association. This certificate was awarded to you by nomination of the Board of Governors and approved by this Eighty-Fifth House of Delegates. I want everyone here to know why they have made this award. I wish to read the citation which will be in the records of the Florida Medical Association forever."

Dr. Jack read the wording of the certificate.

"Florida Medical Association, Inc., Certificate of Merit, Presented to Edward Jelks, M.D., For exceptional and outstanding service to the Associa-

tion, to the medical profession and to the public, as laid down in the Principles of Medical Ethics. Signed: Jere W. Annis, M.D., President; Samuel M. Day, M.D., Secretary."

Dr. Jelks: "Members of the House of Delegates: There are three documents—one is a letter, one a license, another a certificate—which bring to me unlimited satisfaction and gratitude. The letter was received 50 years ago this month, announcing that I was accepted by the medical school of my choice. The license was issued eight years later, authorizing a partnership, which it is surprising that one of the members was willing to enter, since she was well aware of the inconveniences, the interruptions, the self denials that are required of one who takes the position of wife of a physician. The third is this certificate which has just been awarded, and please let me look at this certificate not as an honor to one member of the Florida Medical Association but as recognition that one member over a period of years had the privilege of working with hundreds, perhaps thousands of members of the Florida Medical Association and with members of our home office to the end that we might all achieve the objectives of the Florida Medical Association.

"The partnership will ever treasure this with the enthusiasm and appreciation of an ardent bibliophile who secures a very rare first edition of a great classic.

"We thank you from the bottom of our heart."

Dr. Jack: "As Dr. Annis has told you previously, he has requested at this time to call the House of Delegates into executive session. We will allow a few minutes for our guests to leave. I am asking Mr. Parham to remain."

Dr. Jere Annis addressed the House of Delegates in executive session.

Dr. Homer L. Pearson Jr. pronounced the benediction.

The Eighty-Fifth Annual Meeting of the Florida Medical Association was adjourned at 12:15 p.m. on Wednesday, May 6, 1959.

# CHARTER OF FLORIDA MEDICAL ASSOCIATION, INC.

## ARTICLE I

The name of the corporation is FLORIDA MEDICAL ASSOCIATION, INC., and its principal place of business shall be located in Jacksonville, Duval County, State of Florida.

## ARTICLE II

The general nature of the objects of the corporation is to promote the science and art of medicine and the betterment of public health; to unite the medical profession of Florida into one compact organization and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical education; to strive for the enactment, preservation and enforcement of just medical and public health laws; to promote friendly relationships among physicians and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies, and to carry out these objects of the corporation as a business league not organized for profit, and no part of the net earnings shall inure to the benefit of any private member or individual, as an exempt corporation not for profit within Section 501 (c) (6), 26 U.S.C.A., Internal Revenue Code of 1954.

## ARTICLE III

The qualifications of each member of this corporation shall conform to the qualifications prescribed by that component society which has a charter from this corporation in the territory or boundaries of which each member resides. Any applicant for admission into this corporation shall be admitted into membership upon the certification by the secretary of any component society that he is a member in good standing of such society, and upon the payment of the current annual dues to the Treasurer of this corporation.

## ARTICLE IV

The term for which this corporation is to exist is perpetual.

## ARTICLE V

The names and residences of the subscribers of this Charter are as follows:

H. Mason Smith, M.D., 2602 Sunset Drive, Tampa, Fla.  
Shaler Richardson, M.D., 210 Talbot Ave., Jacksonville, Fla.  
Gerry R. Holden, M.D., 205 Goodwin St., Jacksonville, Fla.  
C. D. Christ, M.D., 508 South Orange Ave., Orlando, Fla.  
Sheldon Stringer, M.D., 801 South Boulevard, Tampa, Fla.

## ARTICLE VI

The affairs of the corporation are to be managed by: a President, a President-Elect, a Vice President or several Vice Presidents if so provided by the By-Laws, a Secretary, a Treasurer, the Immediate Past President, a House of Delegates of not less than three delegates or such additional number as is fixed in the By-Laws, a Board of Governors constituted as provided in the By-Laws and an Executive Committee constituted as provided in the By-Laws. Each officer and member of the House of Delegates, and of the Board of Governors or the Executive Committee, shall be elected or appointed at the time and in the manner fixed in the By-Laws.

## ARTICLE VII

The names of the officers who are to manage all the affairs of this corporation until the first election or appointment of officers under this Charter are as follows:

H. Mason Smith, M.D.  
Shaler Richardson, M.D.  
Gerry R. Holden, M.D.  
C. D. Christ, M.D.  
Sheldon Stringer, M.D.

## ARTICLE VIII

The By-Laws of the corporation shall be made, altered or rescinded by the House of Delegates in the manner fixed by the By-Laws.

## ARTICLE IX

The highest amount of indebtedness or liability to which the corporation may at any time subject itself shall be five million dollars (\$5,000,000.00), provided, however, that the highest amount of indebtedness or liability of the corporation shall never be greater than two-thirds of the value of the property of the corporation.

## ARTICLE X

The amount and value of the real estate which the corporation may hold, subject always to the approval of one of the Judges of the Circuit Court in and for Duval County, Florida, shall be five million dollars (\$5,000,000.00).

## ARTICLE XI

This corporation reserves the right to amend, alter, change, or repeal any provisions contained in this Charter in the manner now or hereafter prescribed by law, and all rights conferred on members in this corporation are granted subject to this reservation.

## BY-LAWS OF FLORIDA MEDICAL ASSOCIATION, INC. CHAPTER 1

### MEMBERSHIP

#### Section 1. QUALIFICATIONS AND ELIGIBILITY

Any doctor of medicine may be accepted into membership in the Florida Medical Association, Inc., upon certification by the secretary of his component society that he is a member in good standing of that society, provided such certification is accompanied by remittance of all required fees, dues and assessments.

#### Section 2. CLASSIFICATIONS

The Association shall be composed of Active Members and Associate Members.

Active Members shall be those Florida licensed doctors of medicine who are certified to the Association by the several component society secretaries as unrestricted members in good standing:

1. Regular active dues-paying members.

2. Life Members.—Any member who has been an Active Member of the Association for thirty-five years shall automatically qualify to become a Life Member and be exempt from all Association dues and assessments as long as he maintains membership in a component society.

3. Members who may be excused from payment of dues by the Board of Governors, as outlined in Chapter 10, Section 2, Item 6.

Associate Members shall be doctors of medicine who may or may not be licensed to practice medicine in the State of Florida and who are certified by the secretary of a component society as members including:

1. Former active members who have completely and permanently retired from active practice, either through choice or through disability.

2. Faculty members of Florida medical schools who are not eligible for active membership.

3. Provisional (probationary) members of component societies pending acceptance into full component society membership. Their associate membership shall terminate as of the end of the probationary period as then fixed in the component society, immediately without any action by the Association or by any of its officers, without refund of any portion of dues and fees paid by the



associate member, upon failure by the component society to advance its provisional member to full membership, or renew his provisional status; but in no event shall such associate membership in the Association exceed a period of two years from the date of the acceptance of a member on probation in a component society.

4. Nonlicensed doctors of medicine who are legal residents of Florida who do not currently hold membership in another state association, and whose previous membership in another state medical association was terminated in good standing and without prejudice.

5. Medical interns, resident physicians and full time staff physicians of hospitals acceptable to the Association.

6. Doctors of medicine in career status with the United States Army, Navy, Air Force, Coast Guard, Public Health Service, Veterans Administration, and Indian Service, and other Federal appointees who do not hold membership in another state medical association.

7. Doctors of medicine of Florida State agencies who are ineligible for active membership.

### Section 3. RIGHTS AND PRIVILEGES

Active Members shall have full rights and privileges in the affairs of the Association including the right to vote and to hold office except that only duly elected and officially seated delegates may vote at meetings of the House of Delegates. Each active member shall be entitled to receive without additional cost an annual subscription to *The Journal of the Florida Medical Association* and one copy of the current *Florida Medical Directory*.

Associate Members may participate in Association activities and are privileged to attend all meetings, sessions and assemblies except that they shall not be privileged to vote or to hold office. Associate members also shall receive an annual subscription to *The Journal* and one copy of the current *Florida Medical Directory*.

### Section 4. SUSPENSION OR INVOLUNTARY TERMINATION OF MEMBERSHIP

The component society shall be the basic unit for censoring, suspending or otherwise disciplining its members. Suspension or termination of membership by component society action shall automatically place the member in the same status in the Association. Any member subject to such action has the right of appeal to the Judicial Council in the manner prescribed in Chapter XI, Section 3, Item 2 of these By-Laws.

Failure of a component society to take adequate and proper action against a member who has been indicted by the Judicial Council shall be deemed sufficient reason for the Judicial Council to take appropriate action which, if resulting in suspension or termination of his membership in the Association, shall require the component society likewise to suspend or terminate his membership in that society or be subject to revocation of its charter.

## CHAPTER II MEETINGS

### Section 1. ANNUAL MEETING

1. **DEFINED.**—The Association shall hold an Annual Meeting which shall be open to all members and invited guests of the Association, members of other state or territorial medical associations, members of the American Medical Association, medical interns and resident physicians from hospitals acceptable to the Association, members of the senior class of recognized medical schools, and doctors of medicine of the medical departments of the military services and other Federal medical agencies.

2. **PLACE AND DATE.**—The Annual Meeting shall be held at the place and time selected by the Board of Governors, subject to confirmation by the House of Delegates.

3. **RIGHT TO ATTEND AND HOLD OFFICE.**—All members of the Association are privileged to attend the sessions and to take part in the activities at the Annual Meeting. Any active member may vote on issues presented at a

General Session, is eligible for any office, and is eligible to serve as a delegate to the House of Delegates of the American Medical Association provided he meets the qualifications specified in the By-Laws of the American Medical Association.

4. **RIGHT TO REGISTER.**—The presentation of proof of current membership in the Association, in any other state or territorial medical association, or in the American Medical Association shall be prima facie evidence of the right to register at the Annual Meeting.

5. **PERSONS PROHIBITED.**—No person who is under sentence of suspension or expulsion from any component society of the Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of the Association, or be permitted to take part in any of its proceedings until such time as he has been relieved of such disability.

6. **REGISTRATION.**—Each member in attendance at an Annual Meeting shall register in person with the registration clerk at the place provided and in the manner in effect at that meeting. No member or delegate is eligible to take part in any proceedings of the Annual Meeting until he has complied with the provisions of this section.

7. **IDENTIFICATION.**—Each person registering at the Annual Meeting shall be issued a badge of such type as to identify properly his category of registration. This badge is evidence of registration and shall be conspicuously displayed at all activities.

### Section 2. SPECIAL MEETINGS

The Board of Governors or House of Delegates may elect to schedule interim or called meetings of the Association when deemed advisable. The Board shall select the place, date, duration, schedule and program of such meetings, with the advice of the Councils and Committees concerned.

A special meeting shall be called by the President upon written request from five or more component societies, or upon written request signed by at least fifty active members of the Association.

## CHAPTER III

### SESSIONS AND ASSEMBLIES

#### Section 1. PARTICIPATION

Each Annual Meeting shall include one or more General Sessions and one or more scientific assemblies at the discretion of the Board of Governors, which, in consultation with the Committee on Scientific Work, shall determine the general program and schedule. Each General Session shall be presided over by the President, or, in his absence or disability, or at his request, by the Vice President. Each scientific assembly shall be presided over by a member of the Committee on Scientific Work.

All persons duly registered are eligible to attend General Sessions and scientific assemblies; however, only *members* are privileged to participate in scientific discussions without special permission from the presiding officer, and only active members may vote on questions pending before a General Session.

#### Section 2. MEDICAL RESEARCH

A member or group of members may recommend to the House of Delegates the establishment of special committees for Medical Research. The Board of Governors shall determine whether funds are available to conduct the projects authorized.

#### Section 3. OFFICIAL PROGRAM

An official program shall be compiled by the Board of Governors in accordance with Section 1 of this chapter and it shall be followed without deviation unless changes are authorized by special vote of the House of Delegates or a General Session.



#### Section 4. SCIENTIFIC PAPERS

The time allotted for presentation of addresses and scientific papers before the Association except in unusual circumstances shall be limited to fifteen minutes except for presentation of the address of the President or of any invited guest of the President. No longer than five minutes shall be permitted for discussion of a scientific paper, and no member shall speak more than once on the same scientific subject.

#### Section 5. CUSTODY OF SCIENTIFIC PAPERS

Any speaker presenting a scientific paper before the Association shall agree to deposit an original copy of the paper with the Secretary prior to or immediately following its delivery. The identical paper shall not have been previously published. Each paper as delivered becomes the property of the Association for such disposition as may be deemed appropriate.

## CHAPTER IV

### HOUSE OF DELEGATES

#### Section 1. DESIGNATION AND COMPOSITION

The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies in accordance with the provisions of these By-Laws, and the officers of the Association as defined in these By-Laws.

#### Section 2. ANNUAL MEETING

The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association. The House shall select the site of Annual Meetings, acting upon the recommendation of the Board of Governors. The President shall deliver an address at a session of the House of Delegates each year.

#### Section 3. CALLED MEETING

The House of Delegates may be called into special session by the President. He shall be required to call a meeting of the House of Delegates upon written request of ten per cent of the current delegates, or any fifty active members of the Association, or three or more component societies, or upon a three-fourths vote of the Board of Governors. Failure to accede to any such request shall be considered authority for the meeting to be called by the Speaker of the House of Delegates. Except in emergencies, delegates shall be notified in writing of a called meeting at least thirty days prior to the date of the meeting.

#### Section 4. INTERIM MEETING

An Interim Meeting of the House of Delegates may be called by the Board of Governors or the House of Delegates.

#### Section 5. QUORUM

At any meeting of the House of Delegates a majority of the eligible delegates shall constitute a quorum, provided that at least a majority of the component societies is represented.

#### Section 6. DETERMINATION OF DELEGATES

Each component society shall be entitled to select annually and to send to each meeting of the House of Delegates one delegate for every twenty active members of the Association within that society, and one for any fraction over and above the last complete unit of twenty, as shown on the Association's records on December 31 of the preceding calendar year, provided that each component society holding a charter from the Association shall be entitled to at least one delegate.

The President, President-Elect, Vice President, Secretary, Treasurer, Immediate Past President, Speaker of the House of Delegates, Vice Speaker, and delegates to the House of Delegates of the American Medical Association shall be ex officio members of the House of Delegates with full rights and privileges.

#### Section 7. DELEGATES TO HOUSE OF DELEGATES OF AMERICAN MEDICAL ASSOCIATION

The House of Delegates shall elect from the active members of the Association representatives to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body in such manner that all delegates are not selected in any one year. Each delegate shall be elected for a two year term.

There shall also be elected one alternate delegate for each delegate, whose term shall coincide with that of the delegate for whom he is the alternate.

#### Section 8. CHARTERS

The House of Delegates shall, upon the recommendation of the Judicial Council and approval of the Board of Governors, issue charters to component societies which have made application and which are organized in accordance with the Charter and the By-Laws of the Association.

#### Section 9. PROCEEDINGS

The official proceedings of the House of Delegates shall be published in The Journal of the Florida Medical Association.

#### Section 10. DELEGATES' CREDENTIALS

The secretary of each component society shall notify the Secretary of the Association which of its members have been selected by the society as delegates to the House of Delegates of the Florida Medical Association as soon as practicable after their election, but not later than February 1. Each delegate so selected shall be in good standing in his component society and shall have paid his current Association dues and assessments.

Each delegate, before being seated, shall present an official certification of eligibility from the president or secretary of his component society to the chairman of the credentials committee.

#### Section 11. TENURE OF DELEGATES

A delegate who has been officially seated at a meeting of the House of Delegates shall remain a delegate of the component society which he represents throughout all sessions of that meeting, and his place shall not be taken by any other delegate or alternate.

Each delegate seated at an Annual Meeting shall serve until the next Annual Meeting, and shall serve at all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different delegate.

#### Section 12. ALTERNATE DELEGATES

Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve. In order to be seated, an alternate must show certification by the president or secretary of his component society.

#### Section 13. VOTING REQUIREMENTS

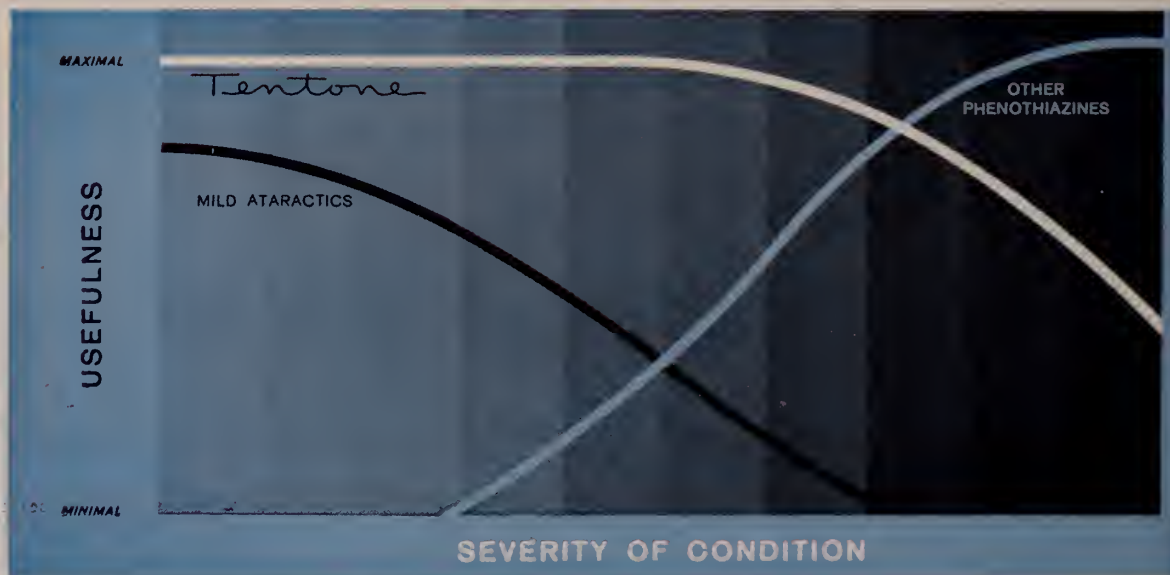
Any seated delegate is privileged to vote on any question before the House of Delegates, but must be present and vote in person. Voting by proxy is prohibited.

#### Section 14. PRIVILEGE OF FLOOR

The privilege of the floor shall be restricted to seated delegates and past presidents, except by permission of the presiding officer.

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## Section 15. REFERENCE COMMITTEES

1. DESIGNATION OF REFERENCE COMMITTEES.—There shall be at least four reference committees to consider and recommend on matters presented to the House of Delegates at its annual meeting: Health and Education, Public Policy, Finance and Administration, and Legislation and Miscellaneous Business. The Speaker of the House shall determine whether additional reference committees are required.

2. REFERENCE COMMITTEE COMPOSITION.—Reference Committees shall be appointed by the President, in consultation with the Speaker, from the members of the House of Delegates. Each committee shall consist of five members, of which three shall constitute a quorum. These appointments shall be published in the Handbook for Members of the House of Delegates and shall be announced at the first session of an annual meeting of the House of Delegates. The President shall designate one member of each reference committee as chairman. Officers and members of the Board of Governors shall not serve on reference committees, and the report of the Chairman of a Standing Committee or the Chairman of a Council shall not be referred to a reference committee of which he is a member.

3. REFERENCE COMMITTEE REFERRALS.—Reports of all officers, of Committee and Council Chairmen, resolutions, measures, proposals and other items of business presented to the House of Delegates at an annual meeting shall be submitted prior to its final session and shall be referred by the Speaker to the appropriate reference committee unless otherwise directed by unanimous consent of the delegates present. Whenever practicable, reports and resolutions shall be submitted to the Secretary of the Association in time to be published in the Handbook.

4. FUNCTIONS OF REFERENCE COMMITTEES.—Each reference committee shall meet in accordance with a schedule designated by the Speaker and as published in the official program to consider all matters referred to it. All meetings of reference committees shall be open to all members of the Association, who shall have the right and privilege to be heard on any issue under consideration. After all eligible persons have had an opportunity to be heard, the chairman may declare an executive session during which the decisions of the committee shall be reached. The chairman shall report the recommendations of the reference committee to the House of Delegates at a subsequent session as directed by the Speaker.

## Section 16. DEFERRED ACTION

All issues not resolved by the House of Delegates and on which further study is directed shall be referred to the Board of Governors for assignment to the appropriate Councils and Committees.

## Section 17. CREDENTIALS COMMITTEE

The President in consultation with the Speaker shall appoint three members of the House of Delegates to pass on credentials submitted by the delegates from the component societies. He shall designate one of the three as the chairman, who shall report to the Speaker at each session the number of delegates officially registered and whether a quorum is present.

## Section 18. HANDBOOK FOR MEMBERS OF HOUSE OF DELEGATES

Prior to each Annual Meeting the Secretary of the Association shall cause to be published a Handbook for Members of the House of Delegates. This Handbook shall contain the agenda for each session of the House, a list of delegates and alternates, the personnel of the credentials committee and the reference committees, and all reports and resolutions received by the time of going to press together with such other information as is deemed advisable. It shall be mailed to each delegate at least thirty days prior to the Annual Meeting.

## CHAPTER V

## ELECTIONS

## Section 1. ELECTION AND TERM OF OFFICE

All officers shall be elected annually by the House of Delegates, and shall serve until their successors are elected and installed.

## Section 2. ELIGIBILITY

Any active member in good standing is eligible for any office provided he meets the provisions set forth in the By-Laws.

## Section 3. METHOD

All elections shall be by secret ballot, unless there is but one nominee for an office, in which instance the Secretary, upon a motion duly made, seconded and carried, shall cast the ballot of the House of Delegates for the nominee. A majority of the votes cast shall be necessary to elect. If no candidate receives a majority vote on the first ballot, a second ballot shall be taken. The names of the two candidates receiving the highest number of votes shall appear on the second ballot. If two or more candidates are tied for second place, their names shall appear on the second ballot. The balloting shall continue until one candidate has a majority.

## Section 4. NOMINATIONS

Nominations for officers of the Association and delegates to the House of Delegates of the American Medical Association shall be made from the floor of the House of Delegates by a member of the House. All active members of the Association are eligible for nomination. Nominating and seconding speeches shall be limited to a maximum of two minutes.

## Section 5. TIME AND PLACE

The election of officers of the Association and delegates to the House of Delegates of the American Medical Association shall be held during the final session of any meeting of the House of Delegates. Only seated delegates shall be eligible to vote.

## Section 6. LIMITATIONS

No member shall hold more than one office at any one time, except that the offices of Secretary and Treasurer may be filled concurrently by the same person.

## CHAPTER VI

OFFICERS AND DELEGATES TO HOUSE  
OF DELEGATES OF AMERICAN  
MEDICAL ASSOCIATION

## Section 1. DEFINED

The officers of the Association are: President, President-Elect, Vice President, Secretary, Treasurer, Immediate Past President, and Speaker of the House of Delegates.

The delegates to the House of Delegates of the American Medical Association are those elected by the House of Delegates as provided in Chapter V, Sections 4 and 5, of these By-Laws.

## Section 2. PRESIDENT

The President is the official head of organized medicine in the State. He shall preside at General Sessions of the Association, appoint all Committees not otherwise provided for, deliver an address at the annual meeting of the House of Delegates and perform such other duties as are normally required of his office. He shall be, ex officio, a member of all Committees without the right to vote, except on the Board of Governors and the Executive Committee where he shall be a member with full rights and privileges. He shall serve as Chairman of the Board of Governors and of the Executive Committee.

### Section 3. PRESIDENT-ELECT

The President-Elect shall be, ex officio, a member of all Standing Committees without the power to vote, except that he shall be a full member of the Board of Governors and the Executive Committee with all rights and privileges. He shall keep himself advised of all programs and activities of the Association and shall familiarize himself with its general policies and procedures. In the event of vacancies in the offices of both the President and the Vice President he shall become the President and serve until a successor has been elected and installed.

### Section 4. VICE PRESIDENT

The Vice President shall succeed to the Presidency for the unexpired term in the event of the death or disability of the President, or his resignation or removal from office. He shall act for the President in case of his temporary absence or disability.

### Section 5. SECRETARY

The Secretary shall attend all sessions of the Association and the House of Delegates unless providentially prevented, in which event he shall be represented by the Executive Director. He shall keep the minutes of their respective proceedings. He shall be, ex officio, a full member of the Board of Governors and the Executive Committee with the right to vote.

He shall be the custodian of all records and papers of the Association, except such as properly belong to the Treasurer. He shall keep account and promptly turn over to the Treasurer all funds received by the Association.

He shall maintain a roster of all licensed doctors of medicine in the State of Florida, noting their status with respect to the relevant component society and the Association. He shall submit to the American Medical Association such reports as may be required regarding licensed doctors of medicine. His office and services shall be available to the officers of the Association, the members of the Board of Governors, Committee and Council Chairmen, and county society officials.

He shall direct official correspondence, notifying members of meetings, and disseminating other notices and announcements as required. All the facilities and personnel of the Executive Office shall be at his disposal. He shall submit a written report annually to the Board of Governors, which shall be published in The Journal.

### Section 6. TREASURER

The Association shall provide bond for the Treasurer in an amount determined by the Board of Governors. He shall receive all funds due the Association, and shall have the supervision of and responsibility for the fiscal affairs of the Association. He shall submit his accounts to an annual audit by a certified public accountant. He shall submit an audited report annually to the Board of Governors, which shall be published in The Journal.

The Treasurer shall maintain a record of all Association entrance fees, dues and assessments paid by members, and likewise shall receive, record and transmit dues and assessments due the American Medical Association. All funds belonging to the Association shall be deposited in a bank or banks approved by the Board of Governors. Investments of reserve funds shall be as directed by the Board of Governors.

### Section 7. SPEAKER OF HOUSE OF DELEGATES

The Speaker of the House of Delegates shall be elected by the House of Delegates from its membership and shall preside over all meetings of the House and shall determine the number and times it shall convene during any one meeting. In consultation with the Speaker, the President shall appoint a credentials committee and all reference committees and shall designate the chairman of each. It is the responsibility of the President to provide a presiding officer for the House of Delegates in the event the Speaker is unable to serve and a Vice Speaker is unavailable. The Speaker of the House of Delegates may be elected to succeed himself only once.

### Section 8. VICE SPEAKER OF HOUSE OF DELEGATES

When deemed advisable, a Vice Speaker may be elected by the House of Delegates from its membership. He shall assist the Speaker and serve in the event of his absence or disability. He shall be an ex officio member of the House of Delegates. The Vice Speaker of the House of Delegates may be elected to succeed himself only once.

### Section 9. DELEGATES TO HOUSE OF DELEGATES OF AMERICAN MEDICAL ASSOCIATION

The Delegates to the House of Delegates of the American Medical Association shall officially represent the Florida Medical Association in that body and shall endeavor to learn the desires and wishes of their constituents and to convert them into action on the national level. They shall seek opinions and suggestions from members of the House of Delegates of the Florida Medical Association and other members of the Association on all matters known or anticipated to be pending before the House of Delegates of the American Medical Association.

Prior to and during a meeting of the House of Delegates of the American Medical Association they shall meet in caucus and confer on pending issues. Whenever possible, the delegates shall present their position as a unified delegation.

Following each meeting of the House of Delegates of the American Medical Association, they shall make a report to the membership and the Board of Governors as soon as practicable. A condensed report of past actions and a preview of anticipated issues shall be presented by one of the delegates to the House of Delegates of the American Medical Association at each annual meeting of the House of Delegates of the Florida Medical Association.

### Section 10. REMOVAL FROM OFFICE AND APPOINTMENT TO FILL VACANCY

Any elected officer or delegate to the House of Delegates of the American Medical Association may be removed from office by a two-thirds vote of the members of the House of Delegates of the Florida Medical Association present and voting at any annual or called meeting of the House.

In the event a vacancy occurs for any reason in an elective office, such vacancy shall be filled by appointment by the President approved by the Board of Governors. Such appointment shall be effective only until the next meeting of the House of Delegates at which time the office shall be filled by election.

## CHAPTER VII BOARD OF GOVERNORS

### Section 1. COMPOSITION

The Board of Governors shall consist of the President, President-Elect, Vice President, Secretary, Speaker of the House of Delegates, the two immediate Past Presidents and five members appointed by the President. The President shall appoint one member from each of the four Medical Districts, with staggered terms, and thereafter they shall be appointed for four years as each term expires. He shall also appoint each year one member-at-large for a term of one year.

The Board, at its discretion, may elect to serve on the Board for a one year term a member of the Florida State Board of Health who is a member of the Association and one of the delegates to the House of Delegates of the American Medical Association. The President shall designate with approval of the Board, one member to serve as Public Relations Officer.

### Section 2. DUTIES AND FUNCTIONS

1. The Board of Governors shall be the executive body of the House of Delegates, provided that it shall take no



action contradicting or contravening an action of the House of Delegates, or which is contrary to the provisions of the Articles of Incorporation or these By-Laws.

2. The Board of Governors shall maintain an Executive Office adequate to administer efficiently and effectively the activities of the Association. It shall employ an Executive Director and other personnel as required to direct and supervise the Executive Office. The Executive Director shall be responsible to the Board of Governors, which shall define his duties and fix his compensation.

3. The Board of Governors shall approve an annual operational budget prepared and submitted by the Executive Director in consultation with the Secretary and the Treasurer. In addition, a financial statement shall be presented at each meeting of the Board.

4. The Board of Governors shall require the Treasurer of the Association to submit for analysis and approval an annual financial report audited by a certified public accountant.

5. The Board of Governors shall be the body responsible for all Councils and Standing Committees and shall receive reports from the Chairman of each Council for inclusion in its annual report to the House of Delegates.

6. The Board of Governors shall recommend to the House of Delegates a site for each Annual Meeting. The Board shall set the dates and approve the program and schedule for all meetings of the Association.

7. The Board of Governors shall publish an official organ of the Association known as The Journal of the Florida Medical Association in a manner hereinafter described:

The Board shall direct and supervise the publication of The Journal and review the general policies and procedures established by the Editor.

The Board shall select annually from the membership at large an Editor whose duties and responsibilities shall be designated by the Board.

The Board shall employ a Managing Editor of The Journal and fix his compensation. He shall be responsible for the technical and mechanical processing of the publication, and shall carry out the directives of the Editor.

8. The Board of Governors shall divide the State into not less than four Medical Districts based insofar as feasible on physician population, and define their boundaries.

### Section 3. MEETINGS

The Board shall meet upon call by the Chairman, or upon the request of any three members of the Board. There shall be a minimum of three meetings in each administrative year.

### Section 4. QUORUM

A majority of the Board shall constitute a quorum.

### Section 5. CHAIRMAN

The President of the Association shall be the Chairman of the Board. In the event of his absence or disability, the Chairman pro tempore shall be the Vice President.

### Section 6. EXECUTIVE COMMITTEE

1. COMPOSITION.—The Executive Committee of the Board of Governors shall consist of the President, President-Elect, Secretary, Immediate Past President, and an optional member who may be appointed by the President with the approval of the Board.

2. DUTIES AND FUNCTIONS.—The Executive Committee shall consider matters referred to it by the President or Board of Governors and shall report its findings and recommendations to the Board. All actions of the Executive Committee shall require the approval or ratification of the Board. This Committee shall be responsible for studying the needs and requirements of the Association and shall engage in long range planning.

The Executive Committee shall be the liaison between the Board of Governors and the Councils and Committees hereinafter outlined. It shall coordinate, direct and supervise the several Councils and Committees and shall receive from them reports and recommendations to be transmitted to the Board of Governors.

3. MEETINGS.—The Executive Committee shall meet at least four times in each administrative year upon call by the President, who shall serve as its Chairman.

4. QUORUM.—A majority of the Executive Committee shall constitute a quorum.

## CHAPTER VIII

### COUNCILS

#### Section 1. ORGANIZATION

Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following Councils:

1. Allied Professions and Vocations
2. Judicial
3. Legislation and Public Agencies
4. Medical Economics
5. Medical Education and Hospitals
6. Medical Services
7. Scientific
8. Special Activities
9. Specialty Medicine
10. Voluntary Health Agencies

#### Section 2. COMPOSITION, SELECTION AND APPOINTMENT TO FILL VACANCY

Unless otherwise provided in these By-Laws, each Council shall be composed of the several Chairmen of the respective Committees in that Council. The term of service on the Council shall coincide with the term as Chairman of the Committee. The President shall appoint annually one member of each Council as its Chairman.

#### Section 3. DUTIES AND FUNCTIONS

In general, the duties and functions of each Council shall be:

Each Council shall coordinate, direct and supervise the several Committees of which it is composed. It shall receive instructions and directives from the Executive Committee and the Board of Governors, and shall make assignments to the appropriate Committees. It shall receive reports from its Committee Chairmen as required and shall include the annual reports of the respective Chairmen in its annual report to the Executive Committee. In addition, each Council shall encourage and aid its Committees in planning and procedures. It may initiate ideas and projects for consideration by the Executive Committee. It shall meet at least once annually on call by its Chairman.

Specifically, the duties and functions of each Council shall be:

1. THE COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS shall maintain liaison with and serve in an advisory capacity to all allied and auxiliary professions officially recognized by the Board of Governors. It shall report its activities regularly to the Board of Governors through the Executive Committee.

2. THE JUDICIAL COUNCIL shall direct and supervise the activities of the Association which pertain to questions of medical ethics, dissension and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association and questions of membership and disciplinary action. It shall maintain liaison with the State Board of Medical Examiners of Florida in connection with licensure policies and procedures. It shall report its activities regularly to the Board of Governors through the Executive Committee.

3. THE COUNCIL ON LEGISLATION AND PUBLIC AGENCIES shall direct and supervise the activities of the Association which pertain to state and national legislation. It shall develop and submit to the House of Delegates through prescribed channels state legislative programs. It shall devise methods to implement such approved programs. It shall assist in promoting national legislative programs sponsored by the American Medical Association and



approved by the Florida Medical Association. It shall maintain liaison with officials of state and national governmental agencies. It shall report its activities regularly to the Board of Governors through the Executive Committee.

4. THE COUNCIL ON MEDICAL ECONOMICS shall direct and supervise the activities of the Association pertaining to all forms of insurance affecting the membership including professional liability, disability, group life and deferred income insurance. It shall maintain liaison with Blue Shield of Florida and commercial health insurance agencies. It shall advise on industrial medicine relations and contracts with the Federal government such as Medicare and veterans' medical services. It shall serve as a clearing house on fee schedules and other questions affecting the economics of medicine. It shall report its activities regularly to the Board of Governors through the Executive Committee.

5. THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS shall direct and supervise those activities of the Association which pertain to medical education in medical schools and hospitals. It shall study and investigate any aspect of medical school activities and intern and resident training, and it shall submit recommendations to the Executive Committee. It shall maintain liaison with all recognized medical schools in the State of Florida. It shall report its activities regularly to the Board of Governors through the Executive Committee.

6. THE COUNCIL ON MEDICAL SERVICES shall direct and supervise the activities of the Association which normally are classified as medical services including those Committees listed under this Council in Chapter IX, Section 1. It shall study and investigate the methods under which medical services are furnished and organized, and it shall submit recommendations to the Executive Committee. It shall act in liaison with labor organizations with relation to problems of medical policy and procedure. It shall report its activities regularly to the Board of Governors through the Executive Committee.

7. THE SCIENTIFIC COUNCIL shall direct and supervise activities of the Association which pertain to The Journal and other scientific publications, the schedule and program of all Association meetings, postgraduate education, and all scientific research as directed by the House of Delegates or the Board of Governors. It shall report its activities regularly to the Board of Governors through the Executive Committee.

8. THE COUNCIL ON SPECIAL ACTIVITIES shall maintain liaison with and serve in an advisory capacity to the Woman's Auxiliary to the Florida Medical Association, the Board of Past Presidents, the delegates to the House of Delegates of the American Medical Association, and the officers of the component medical societies.

9. THE COUNCIL ON SPECIALTY MEDICINE shall maintain liaison with and serve in an advisory capacity to all organized specialty groups officially recognized by the Board of Governors. It shall report its activities regularly to the Board of Governors through the Executive Committee.

10. THE COUNCIL ON VOLUNTARY HEALTH AGENCIES shall maintain liaison with and serve in an advisory capacity to all Voluntary Health Agencies officially recognized by the Board of Governors. It shall report its activities regularly to the Board of Governors through the Executive Committee.

## CHAPTER IX

### COMMITTEES

#### Section 1. ORGANIZATION

Directly responsible to and reporting through their respective Councils shall be the following Standing Committees of the Association:

THE COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS: Committees on Dentistry, Law, Medical Secretaries and Assistants, Medical Technicians, Nursing, Pharmacy, Physical Therapy, Veterinary Medicine, and X-ray Technicians.

THE JUDICIAL COUNCIL: Committees on Grievances, Medical Licensure, Membership and Discipline, and Necrology.

THE COUNCIL ON LEGISLATION AND PUBLIC AGENCIES: Committees on State Legislation with a Subcommittee on Liaison with State Agencies; and National Legislation, with a Subcommittee on Liaison with Federal Agencies.

THE COUNCIL ON MEDICAL ECONOMICS: Committees on Blue Shield, Commercial Health Insurance, Fee Schedules, Industrial Medicine, Medicare and Members' Insurance.

THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS: Committees on Hospitals, Internships and Residencies, Medical Schools, and Physician Placement.

THE COUNCIL ON MEDICAL SERVICE: Committees on Aging, Blood, Cancer, Child Health, Conservation of Vision, Emergency Medical Service, Indigent Care, Labor, Maternal Welfare, Mental Health, Public Health, and Rural Health.

THE SCIENTIFIC COUNCIL: Committees on The Journal and Other Publications, Postgraduate Education, Research, and Scientific Work.

THE COUNCIL ON SPECIAL ACTIVITIES: Committees on Advisory to Woman's Auxiliary to Florida Medical Association, Board of Past Presidents, Delegates to House of Delegates of American Medical Association, and Liaison with Component Societies.

THE COUNCIL ON SPECIALTY MEDICINE: Committees on Allergy, Anesthesiology, Chest Physicians, Dermatology, General Practice, General Surgeons, Industrial and Railway Surgeons, Internal Medicine, Neurosurgery, Obstetrics and Gynecology, Ophthalmology and Otolaryngology, Orthopedics, Pathology, Pediatrics, Plastic Surgery, Proctology, Psychiatry, Radiology, Surgery, and Urology.

THE COUNCIL ON VOLUNTARY HEALTH AGENCIES: Committees on Arthritis and Rheumatism Foundation, Cancer, Cerebral Palsy, Diabetes, Heart, Mental Health, Muscular Dystrophy, National Foundation, and Tuberculosis Association.

#### Section 2. COMPOSITION, SELECTION AND TENURE OF COMMITTEES

Special Committees for specific purposes may be established by the Board of Governors or the House of Delegates. These Committees shall be Subcommittees to the Board of Governors and shall be appointed by the President subject to approval by the Board. The number and qualifications of the members of the Subcommittees shall be determined by the particular requirement of the project. A Subcommittee shall be automatically terminated upon completion of its assignment and may be terminated at any time by majority vote of the originating body.

Regular Standing Committees, unless otherwise provided in these By-Laws, shall each be comprised of five active Florida Medical Association members, one from each of the four Medical Districts and one from the membership at large, all appointed by the President. The representatives from the Medical Districts shall be appointed to four year terms on a staggered basis. The member-at-large shall be appointed annually for one year. On newly established Committees, appointments shall be on a staggered basis of one to four years. The President shall designate, annually, one member of each Committee as its Chairman.

Special Standing Committees shall be:

1. ALLIED PROFESSIONS AND VOCATIONS COMMITTEES.—Each Committee under the Council on Allied Professions and Vocations shall consist of one member appointed annually by the President of the Association in Consultation with the president or designated official of each allied group.

2. GRIEVANCES.—This Committee shall be composed of the five living Immediate Past Presidents. It shall elect its own Chairman.

3. THE JOURNAL AND OTHER PUBLICATIONS.—The Jour-

nal of the Florida Medical Association is the official organ of the Association. It shall be organized and operated in accordance with the provisions established in these By-Laws.

The Board of Governors shall select annually an Editor from the membership at large. The Editor shall appoint annually, subject to the Board's approval, the Assistant Editors, and an editorial staff, which shall include a book review editor, an abstract editor, a committee on publications, a committee on advertising, and such other posts and committees as shall be deemed advisable.

4. MEDICAL LICENSURE.—This Committee shall be composed of the president and the secretary of the State Board of Medical Examiners of Florida and one member-at-large from the Association appointed annually by the President of the Association.

5. MEDICAL SCHOOLS.—This Committee shall be composed of seven members appointed by the President of the Association, who shall select one member from the medical faculty of the University of Miami School of Medicine and one member from the medical faculty of the College of Medicine of the University of Florida; one member of the Dade County Medical Association and one member of the Alachua County Medical Society; one member each from Medical Districts "A" and "C" of the Florida Medical Association; and one member from the Florida Medical Association at large. These appointments shall be for four years except that the initial terms shall be staggered to provide for a minimum change of members in any one year.

6. MEDICARE.—This Committee shall be composed of a minimum of six members selected by the President to include representatives of the medical practice fields of Obstetrics and Gynecology, General Surgery, General Practice, Internal Medicine, Pediatrics, and Radiology. The Committee may be increased by direction of the Board of Governors or upon request by the Chairman. The members shall be selected as equitably as possible from the four Medical Districts, and their terms of four years shall be staggered to provide for a minimum change of members in any one year.

7. MEMBERSHIP AND DISCIPLINE.—This Committee shall be composed of two members of the Association from each Congressional District, elected for four year terms on a staggered basis by the House of Delegates annually from a slate of nominees presented by the Board of Governors.

8. NATIONAL LEGISLATION.—This Committee shall be composed of a key contact physician from each Congressional District in the State and one for each United States Senator from Florida. The members shall be selected annually by the American Medical Association's key contact physician for the State, subject to approval by the Board of Governors. The American Medical Association's key contact physician shall normally serve as Chairman at the discretion of the Board of Governors.

SUBCOMMITTEE ON LIAISON WITH FEDERAL AGENCIES.—This Subcommittee shall be composed of one physician for each Federal agency engaged in health services. The members shall be selected annually by the Chairman of the Committee on National Legislation, subject to approval by the Board of Governors. The President shall appoint one member of the Subcommittee as Chairman.

9. RESEARCH.—This Committee shall exist only when study of a specific scientific research problem has been directed by the House of Delegates or the Board of Governors. Its composition and tenure shall be designated by the Board of Governors.

10. SPECIALTY MEDICINE COMMITTEES.—Each Committee under the Council on Specialty Medicine shall consist of one member appointed annually by the President of the Association in consultation with the president of each specialty group within the State.

11. STATE LEGISLATION.—This Committee shall be a regularly constituted committee; however, under its jurisdiction and supervision there shall be a Subcommittee on Liaison with State Agencies composed of the Chairman, and one member from each Advisory Committee to State Agencies, designated annually by the President of the Association.

12. VOLUNTARY HEALTH AGENCIES COMMITTEES.—Each Committee under the Council on Voluntary Health Agencies shall consist of one member appointed annually by the President of the Association in consultation with the State president or designated official of each voluntary health agency operating within the State and approved by the Board of Governors.

13. ADVISORY COMMITTEE TO BLUE SHIELD.—This Committee shall be composed of seventeen members consisting of a Chairman and sixteen members, four from each Medical District appointed by the President with staggered terms. The various fields of medicine shall be represented.

### Section 3. DUTIES AND FUNCTIONS

The general duties and functions are applicable to all Committees under each Council unless specifically provided otherwise in these By-Laws. Each Committee shall be responsible for activities and projects in the appropriate field as assigned to it by the Council under which it operates and through which it reports to the Executive Committee and the Board of Governors. Each Committee may initiate ideas and projects for submission to the appropriate Council. The Chairman of each Committee may request through channels that the President of the Association appoint subcommittees for specific ad hoc assignments in related subjects. Committee Chairmen or members shall not obligate the Association for funds except as expressly authorized by the Board of Governors.

The specific duties and functions shall be:

1. THE ADVISORY COMMITTEE TO BLUE SHIELD shall serve in an advisory capacity to Blue Shield of Florida and as a reference committee of the Board of Governors for problems pertaining to Blue Shield. It shall when indicated consult with other interested Committees and the Council on Specialty Medicine in the study of fee schedules and medical service contracts.

This Committee and the Council on Specialty Medicine shall serve jointly as the Blue Shield Liaison Committee, formerly known as the Committee of Seventeen. The Chairman of the Advisory Committee to Blue Shield shall serve as Chairman of the joint Blue Shield Liaison Committee.

2. THE COMMITTEE ON COMMERCIAL HEALTH INSURANCE shall serve as liaison with the Health Insurance Council and other acceptable organizations designated by the insurance industry. It shall consult with other appropriate Committees and the Council on Specialty Medicine whenever necessary.

3. THE COMMITTEE ON FEE SCHEDULES shall be responsible for the study, development, or modification of all fee schedules accepted or endorsed by the Association. It shall consult with other appropriate Committees and with the Council on Specialty Medicine whenever necessary.

4. THE GRIEVANCE COMMITTEE shall hear and weigh complaints from the public relative to the profession and to medical practices. It shall be empowered to investigate such complaints or refer them to the grievance committee of the appropriate component society.

If a complaint referred to a component society is not adjudicated expeditiously or satisfactorily, the Grievance Committee shall attempt to determine what has caused the delay or dissatisfaction and shall reopen the case on the Association level if such a procedure is deemed necessary and advisable. If the findings indicate that censorship or other disciplinary action against the member or members against whom the complaint was filed is in order, the Committee shall request that this action be taken by the member's component society. Failure of the society to comply with the request shall be cause for referral of the matter to the Judicial Council.

Each member against whom charges are preferred shall have such charges presented to him in writing and shall have the opportunity, if desired, to appear before the Committee.

5. THE COMMITTEE ON HOSPITALS shall serve as liaison with the Florida Hospital Association and shall handle all Association matters which mutually concern hospitals and physicians.

6. THE COMMITTEE ON INTERNS AND RESIDENTS shall sponsor standards of resident and intern training consistent with those of the American Medical Association



and shall assist in the development and expansion of such training programs throughout the state.

7. THE COMMITTEE ON THE JOURNAL AND OTHER PUBLICATIONS shall direct and supervise the publication of The Journal. It shall be responsible for the establishment of editorial policies and procedures, provided they are not in conflict with or do not abrogate any section of these By-Laws or any directive of the House of Delegates or the Board of Governors. It shall also be responsible for the selection of scientific articles for publication and the preparation of editorials for publication. In addition, this Committee shall set advertising standards for advertising in The Journal and its other publications and shall pass on requests for space or advertising copy not previously approved by the State Journal Advertising Bureau or similar approving agency.

8. THE COMMITTEE ON MEDICAL LICENSURE shall from time to time review the State laws dealing with medical licensure and make recommendations to the Board of Governors through channels for changes or corrections. It shall receive, review, and make recommendations on all proposals dealing with medical licensure in the State. It shall serve as liaison with the State Board of Medical Examiners of Florida.

9. THE COMMITTEE ON MEDICAL SCHOOLS shall serve as liaison with the recognized medical schools in Florida and shall act in an advisory capacity to these institutions in fostering high standards of medical education. It shall encourage administrators of medical schools in the State to exercise controls over the extent of private practice by members of their faculties in order to maintain proper relationship between teaching responsibilities and private practice.

10. THE COMMITTEE ON MEDICARE shall serve as a mediation committee to review claims by members of the Association for payment in connection with the program to provide medical care by civilian physicians to eligible dependents of members of the uniformed services.

11. THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE shall from time to time review membership classifications and make recommendations. It shall receive from the Judicial Council reports of disputes between members, between a member and his component society, between a member and the Association, between component societies, and between a component society and the Association. It shall investigate these reports and make recommendations to the Chairman of the Judicial Council as to disposition. In addition, it shall receive, study and investigate all matters pertaining to medical ethics and shall make recommendations to the Chairman of the Judicial Council. It shall also serve as the Committee to investigate complaints regarding medical testimony.

12. THE COMMITTEE ON PHYSICIAN PLACEMENT shall endeavor to bring together qualified licensed doctors of medicine and communities desiring and needing additional medical services. This Committee shall also serve in an advisory capacity to the Florida State Board of Health for medical student scholarships as provided in Chapter 458.081, Florida Statutes.

13. THE COMMITTEE ON POSTGRADUATE EDUCATION may organize and conduct postgraduate courses, seminars and similar educational programs that have been approved by the Board of Governors. These courses normally shall be financed by registration fees collected by the Committee and deposited with the Treasurer of the Association. Disbursements shall be by Association check for items approved by the Board of Governors based upon a previously submitted budget. This Committee shall have the authority to select a faculty from among outstanding medical authorities and educators, and recognized professional experts and leaders in other scientific fields. It shall endeavor to maintain close liaison and cooperation with all recognized medical schools in the State of Florida.

14. THE SCIENTIFIC RESEARCH COMMITTEE shall be appointed by the President to carry out special activities in scientific research as directed by the House of Delegates or the Board of Governors. The duties, objectives, limitations and tenure of such a Committee shall be clearly defined by the designating body. Each Committee

shall be restricted to scientific research in a specific field and shall be required to report its findings and recommendations to the Board of Governors through prescribed channels. In establishing a research project a definite appropriation shall be determined in advance, and the Committee shall be expressly prohibited from incurring obligations beyond this sum unless authorized to do so by the Board of Governors.

15. THE COMMITTEE ON SCIENTIFIC WORK shall concern itself with the character and scope of the scientific activities of the Association, including the scientific assemblies, motion picture films, television and radio programs and scientific exhibits. It shall prepare a scientific program for each meeting, which shall be submitted to the Board of Governors through channels for approval and inclusion in the general program, and it shall be responsible for the selection of the scientific papers and scientific exhibits to be presented at each meeting. Also, it shall see that the scientific papers presented before the Association become the exclusive property of the Association and collect and turn over these papers to the Secretary of the Association. A member of this Committee shall preside at each scientific assembly.

## CHAPTER X INCOME AND EXPENDITURES

### Section 1. OPERATING FUNDS

Funds for operating the Association shall be provided by annual per capita dues on each member in an amount set by the House of Delegates, by advertising revenue from official publications and exhibits, by investment of reserve funds, by voluntary contributions, by special assessments voted by the House of Delegates, and by revenue from other sources as authorized by the House of Delegates or Board of Governors.

### Section 2. DUES

1. ANNUAL DUES.—Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be \$40.00 per year for active members and \$25.00 per year for associate members, except that medical interns and full time resident physicians shall be required to pay only \$10.00 annual dues. Included in all dues is an annual subscription to The Journal of the Florida Medical Association and one copy annually of the current Florida Medical Directory.

2. ENTRANCE FEE.—Each new active or associate member shall be required to pay an entrance fee of \$10.00 in addition to his annual dues.

3. REINSTATEMENT.—To obtain reinstatement to active or associate membership after being involuntarily dropped from the Association's roster for nonpayment of dues, an applicant shall be required to pay dues for the year in which he was delinquent in an amount equal to the dues in effect at that time, in addition to dues for the current year.

Former members who voluntarily severed their membership and were in good standing at that time shall be charged a readmission fee of \$10.00 in addition to the current year's dues.

4. PRORATION OF DUES.—New members who join the Association on or after July 1 of any year shall be required to pay dues for one-half of that year only in addition to the entrance fee.

Members entering obligatory military service on or before July 1 of any given year shall be required to pay dues for one-half of that year only. Likewise, if discharged or released to inactive duty on or after July 1, they shall be required to pay dues for only one-half of that year.

5. DELINQUENCY.—An active or associate member whose annual dues have not been received by the Association through his component society on or before February 1 of the current year shall be considered delinquent. He shall be notified of such delinquency by the Secretary of the Association by letter mailed to his last known address. If payment has not been received on or before December 31 of that year, he shall be sum-



marily removed from the membership roll of the Association.

6. **EXEMPTIONS.**—Dues for active or associate members may be waived by the Board of Governors upon application by the member and upon approval by his county medical society for permanent or temporary absence from practice due to illness or other disability; unequivocal retirement from active practice; attainment of the age of 70 years whether or not still in practice; interruption of practice for postgraduate study for a period of time not to exceed four years; and obligatory military duty so long as the member reports annually, except in time of a national emergency, to the Association, certifying that he is still involuntarily retained in service, provided he is also retained as a member in good standing of his component society. It is the member's responsibility to advise the Association of the beginning, continuation, and termination of his military service. The Association shall assume no obligation for failure of the member to comply with this provision.

Dues shall be automatically waived for the secretary or treasurer of each component society. The component society shall designate for which officer dues are to be waived.

7. **COLLECTION AND REMITTANCE OF DUES.**—Each component society shall collect all dues and assessments due the Florida Medical Association and the American Medical Association and forward them to the Secretary of the Florida Medical Association on or before February 1 annually. After this date, each member from whom the Association has not received payment in full through his component society official shall be declared delinquent, and he and the secretary of his component society shall be so notified.

### Section 3. EXPENDITURES

Funds shall be expended in accordance with an annual operating budget prepared by the Executive Director in consultation with the Secretary and Treasurer and approved by the Board of Governors. Expenditures not covered in the budget shall require prior endorsement by the Board.

All motions and resolutions appropriating monies approved by the House of Delegates shall specify the amount and purpose for which such monies are to be expended. They shall become effective only when they are determined by the Board of Governors to be economically feasible and within the available financial resources of the Association.

Allocations of funds by the Board of Governors shall be accomplished in closed session only.

## CHAPTER XI COMPONENT SOCIETIES

### Section 1. CHARTERS

The component societies of the Association shall be all of the county medical societies now chartered by the Association and those that hereafter may be organized and chartered by the Association which have adopted constitutions and by-laws or have been incorporated with by-laws not in conflict with the Articles of Incorporation and the By-Laws of the Association.

Charters shall be issued by the House of Delegates upon the recommendation of the Judicial Council. The House of Delegates shall have authority to revoke the charter issued to any component society whose actions are in conflict with the letter or spirit of these By-Laws or of the Articles of Incorporation of the Association.

A copy of the constitution and by-laws, or of the corporate charter and by-laws, of each component society shall be filed in the Executive Office of the Association, and the Association shall be notified promptly of any changes therein.

### Section 2. ONE SOCIETY IN EACH COUNTY

Only one component society shall be chartered in any county. Physicians in counties having few physicians

may, upon mutual agreement, join with physicians in adjacent counties in the formation of a combined society which shall have all the rights, privileges, duties, responsibilities and obligations of a society composed of physicians of only one county.

### Section 3. MEMBERSHIP

1. **QUALIFICATIONS AND REQUIREMENTS.**—Each component society shall establish its requirements for membership and shall judge the qualifications of its applicants. Since membership in a component society is a prerequisite to membership in the Florida Medical Association and the American Medical Association, every reputable and licensed doctor of medicine in his respective county who is practicing, or who will agree to practice, nonsectarian medicine, shall be privileged to apply for membership.

2. **APPEALS.**—Any doctor of medicine who has been denied membership in the component society of his county, or who has been suspended or expelled, may appeal to the Judicial Council, which, upon a majority vote, may grant him permission to apply for membership in an adjacent component society.

Any member of a component society who is in disagreement or altercation with his society may appeal to the Judicial Council for a review of his complaint.

3. **TRANSFERS.**—When a member in good standing of a component society moves to another county in the state, his name shall be transferred to the roster of the component society of his new location, upon certification by the secretary of that society that he has been accepted into unqualified membership. He shall not be required to pay additional dues to the Association for the current year.

If the component society into which he wishes to transfer requires a probationary period before acceptance into full membership, he may pay his Florida Medical Association and American Medical Association dues directly to the Association during his period of probation, provided the secretary of that component society certifies to his status as a probationary member. This privilege is limited to a maximum of two years for any one transfer, as provided in Chapter I, Section 2, Item 3.

4. **MEMBERSHIP IN ANOTHER COUNTY.**—A physician living in close proximity to a county line may apply for membership in the component society most convenient for him upon mutual agreement of both societies involved. No member may hold simultaneous active membership in more than one county medical society.

5. **MEMBERSHIP IN FLORIDA MEDICAL ASSOCIATION REQUIRED.**—Each component society holding a charter from the Association shall require all of its eligible members who are doctors of medicine to be members also of the Florida Medical Association.

6. **MEMBERSHIP REPORTED ANNUALLY.**—The secretary of each component society shall be furnished annually a roster of all of its Florida Medical Association and American Medical Association members, and shall advise the Association of any changes on or before February 1 of each year. This shall be an official report and shall be utilized by secretaries of component societies in the remittance of dues, assessments and entrance fees. All new members of each society shall be added to the list by the society secretary, as shown on the Association records on December 31 of the preceding year.

7. **MINIMUM MEMBERSHIP OF COMPONENT SOCIETIES.**—Each component society shall be required to have a minimum of five members to retain its charter. Should the number of active members of any component medical society fall below a total of five, it shall be the duty of the Judicial Council to make an effort to increase the membership of that society to meet the minimum requirement. If this effort fails, the society shall be subject to revocation of its charter at the next annual meeting of the House of Delegates.

### Section 4. ROLE OF COMPONENT SOCIETY

Each component society shall assume general direction of the affairs of the medical profession in the area of its jurisdiction. It shall constantly strive for the scientific, moral and material advancement of all doctors

of medicine and for the improvement of medical services and health facilities locally.

#### Section 5. MEETINGS

Each component society shall determine the nature and frequency of its meetings, but shall strive to emphasize the scientific improvement of its members.

#### Section 6. DELEGATES TO HOUSE OF DELEGATES OF FLORIDA MEDICAL ASSOCIATION

Each component society shall be entitled to representation in the House of Delegates of the Florida Medical Association by one delegate for each twenty active members, and one additional delegate for any fraction over and above the last unit of twenty. Each society, however, shall be entitled to at least one delegate.

These delegates shall be elected not later than the society's last meeting of the calendar year, and shall be reported to the Secretary of the Association on or before February 1 of the following year.

### CHAPTER XII

#### RULES OF CONDUCT

The principles as set forth in the Principles of Medical Ethics of the American Medical Association shall be the Principles of Medical Ethics for the Florida Medical Association and shall govern the conduct of the members of the Association in their relations to each other and to the public. Opinions of the Judicial Council of the American Medical Association shall be used as a guide in the interpretation of these principles.

### CHAPTER XIII

#### RULES OF ORDER

The deliberations of the Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, Revised, unless otherwise provided in the Charter and these By-Laws, or unless waived or modified by a two-thirds vote of members present at any session of the general membership or meeting of the House of Delegates.

### CHAPTER XIV

#### AMENDMENTS

##### Section 1. BY-LAWS AMENDED

These By-Laws may be amended at any annual meet-

ing of the House of Delegates by a majority vote of all the delegates present at that meeting after the amendment has been acted upon by a reference committee and has laid upon the table for at least one day.

##### Section 2. ARTICLES OF INCORPORATION AMENDED

The Articles of Incorporation may be amended by resolution adopted in the same manner as an amendment to the By-Laws.

### CHAPTER XV

#### SEAL

The Association shall have a common Seal, with power to change, renew or break it at pleasure.

### CHAPTER XVI

#### REFERENDUM

##### Section 1. REQUEST FROM HOUSE OF DELEGATES

Any question pending before or acted upon by the House of Delegates shall be submitted to the active membership in general referendum upon request and approval of two-thirds of the delegates present and voting.

##### Section 2. REQUEST FROM MEMBERS

In similar manner the active membership in General Session, and comprising a minimum of ten per cent of the total number of active members, may direct a general referendum on any action of the House of Delegates upon approval of two-thirds of the members present and voting.

##### Section 3. APPROVAL

A majority vote of the active members of the Association by direct ballot can revoke an action of the House of Delegates except an amendment to the Charter or By-Laws, which shall be submitted for consideration in the manner provided for amendments, Chapter XIV, Sections 1 and 2.

## Scientific Assemblies

The Scientific Assemblies convened at 9:30 a.m., and 2 p.m. on Tuesday, May 5, in the Grand Ballroom of the Americana Hotel. Presiding at the morning session were Drs. Richard Reeser Jr. of St. Petersburg, and Dr. John M. Packard of Pensacola.

The following papers were read and discussed:

"Polio-Like Diseases in South Florida," M. Michael Sigel, Ph.D.; M. J. Takos, M.D.†; G. G. Schlaepfer, B.A.; M. C. Launer and R. V. Catling, R. N., Miami. Presented by Dr. Sigel.

"Spontaneous Pneumothorax: Its Complications and Treatment," Nelson H. Kraeft, Tallahassee.

"Clinical Variations in Thyrotoxicosis," Miles J. Bielek, Fort Lauderdale.

"Problems Encountered in a Vascular Clinic," Clyde M. Collins, John H. Terry and Robert H. Still Jr., Jacksonville. Presented by Dr. Collins.

"Arterial Aneurysms: Florida's Problems," David S. Hubbell, St. Petersburg.

"Experimental and Clinical Use of Intraven-

ous Fibrinolysin Therapy," Paul W. Boyles, Miami.

Presiding at the afternoon session were Drs. Franz H. Stewart, Miami, and George T. Harrell, Gainesville.

The following papers were read and discussed:

"Facial Pain," C. MacKenzie Brown, Tampa.

"The Office Diagnosis of Masked Depression," Robert G. Steele, Sarasota.

"Central Angiospastic Retinopathy, an Ocular Vasoneurotic Syndrome," Thomas S. Edwards, Jacksonville.

"Automobile Crash Injury Research," Paul W. Braunstein, New York.

"Accident Proneness in the Automobile Accident Field," Frank E. Maloney, LL.B., Gainesville.

"Physical Impairments as They Relate to Accidents," Captain C. W. Keith, Tallahassee.

"Accidents, A Family Problem," Mr. Harry C. Steed Jr., Atlanta.

† Deceased

## Registration

The total registration for the 85th annual meeting at Bal Harbour was 2,059. The registrants include 1,022 members of the Association, 179 visiting physicians, 122 other guests, 386 members and guests of the Woman's Auxiliary, 51 scientific exhibitors and 299 representatives of exhibiting firms. There were 25 other states and 4 foreign countries represented.

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#### Visiting Doctors

BARTOW: Charles T. Dunham. BOYNTON BEACH: Richard Manthey. BRADENTON: Frederick K. Allen, Frederick L. Patry, Summer Quimby. CORAL GABLES: James W. Gibson, Lance G. G. Glasson, Samuel C. Kaim, Jack Reiss. FT. LAUDERDALE: John R. Ashcraft, Robert T. Braman, Francis S. Creighton, Richard M. Ewing, H. Donald Hill, John D. Liechty, Franklin B. Ott, Warren V. Stough, Robert B. Walker, Leo Whitman. FORT PIERCE: Niels B. Jorgensen. GAINESVILLE: Myron W. Wheat Jr., Edward R. Woodward. HIALEAH: Theodore Hirsch. HOLLYWOOD: Milton G. Abarbanel, Donald C. Bullington, S. J. Hodkin, Myron Segal. HOMESTEAD: Charles F. Frey. INDIAN LAKE ESTATES: Bruce Newell Jr., JACKSONVILLE: John L. Enyart, Amelia Sheftall Geeslin, Robert J. Jarrell, Hubert L. King. KEY WEST: C. F. Aquadro, John M. Cammarata, James L. Wardlaw Jr. LAKELAND: Stanley W. Lipinski.

MIAMI: Joseph I. Anton, Thomas J. Baker, Louis D. Bennett, Leonard N. Brodsky, Sol Center, Gwen S. Connor, O. William Davenport, Ettore DeGirolami, Joseph E. Glassberg, Maxwell M. Greenhouse, Richard M. Mann, Daniel S. Martin, Samuel Novell, Helga Christine Ossoinig, Enrique Peirano, Irwin M. Potash, George R. Prout Jr., Martin Rosenthal, William F. Schan, Elias H. Schlomovitz, Marie M. Schuh, Bernard Sigel, Thomas W. Skaggs, John S. Stanley, Edward A. Talmadge. MIAMI BEACH: Jerome Benson, Jack L. Cantor, Lu Fernandez, Luis L. Galang, Samuel A. Gluck, Joseph Harris, R. D. Miller, Harry A. Moscoe, F. E. Popoff, Ben-Henry Rose, A. M. Rywlin, Hans-Hanning Storch, Anna Weintraub, Victor

F. Woldman. MIAMI SPRINGS: Ralph Skowron. NORTH MIAMI: Gabino S. Cuevas, Charles Russell Sherman.

ORLANDO: Julia B. Edwards, Don Grimes, George A. Thompson. PALM BEACH: Henry Ward Williams. PALM BEACH SHORES: Albert T. Ransone. PANAMA CITY: Theodore G. Elchos. PERRINE: Alfred Glattauer. POMPANO BEACH: F. X. Straessley. RAIFORD: Reginald C. Ramsay. ST. PETERSBURG: Alfred D. Koenig. SARASOTA: S. Preston Clement Jr. TALLAHASSEE: Paul J. Coughlin. TAMPA: William A. Moore, III, A. Ruiz, Sorrell L. Wolfson. WEST PALM BEACH: Charles C. Dugan, Alan E. Zimmer.

ALABAMA-BIRMINGHAM: David H. Sparks, Arthur W. Woods. REPTON: William R. Carter. CALIFORNIA-BEVERLY HILLS: Albert H. Levine. LONG BEACH: J. T. Fowler Jr. LOS ANGELES: Marvin S. Freilich, Erle Henriksen. OAKLAND: Lindsay C. Getzen. SAN FERNANDO: Harold E. Petersen. CONNECTICUT-BRIDGEPORT: David Nagourney. WATERBURY: Charles H. Audet Sr. GEORGIA-AUGUSTA: W. W. Hamilton. CALHOUN: J. LeRoy Rabb. ST. MARYS: John R. Doster. SAVANNAH: Lee Howard, Samuel F. Rosen.

ILLINOIS-CHICAGO: F. J. L. Blasingame, Donald B. Frankel, Rose L. Gorday, Jack Mandel, Julius I. Mandel, F. J. PaDour, Joel F. Sammet. GLENCOE: Irwin Dvore. INDIANA-GARY: Herbert M. Baitinger. IOWA-IOWA CITY: Charles R. Eicher.

KANSAS-KANSAS CITY: Fred E. Tosh. WICHITA: George F. Corrigan. LOUISIANA-ALEXANDRIA: Stanley S. Goodman. NEW ORLEANS: Harold Cummins. SHREVEPORT: J. S. Shavin. MASSACHUSETTS-BOSTON: Ethan Allan Brown, George F. Wilkins. MICHIGAN-DETROIT: John E. Clifford, Maurice P. Meyers. GRAND RAPIDS: Willis E. Gouwens. ROYAL OAK: John Lee Barrett. ST. CLAIR: Joseph F. Beer. MINNESOTA-EXCELSIOR: Roger Stanley Johnson. ST. PAUL: Charles C. Cooper. MISSOURI-ST. LOUIS: A. H. Diehr. NEW HAMPSHIRE-MANCHESTER: Rebecca Cohen. NEW JERSEY-PERTH AMBOY: Bori Berkow.

NEW YORK-ALBANY: Seymour Nichter. BROOKLYN: William Lehrich, Samuel M. Podwell. BUFFALO: Joseph E. Griffin, L. Maxwell Lockie, John J. O'Brien. GREAT NECK: Louis J. Lester. LYNBROOK: S. Paul Zola. NEW YORK CITY: Thomas H. Alphin, Arthur Bamberger, Paul W. Braunstein, Edward J. Folmer, Harry Grabstad. PEEKSKILL: Stuart S. Pines. OHIO-CINCINNATI: Melvin B. Fishman, Harry O. Lepsky. CLEVELAND: Thomas C. Kenaston Jr., Irvine H. Page, A. G. Palmieri, Robert Rogoff. TOLEDO: Floyd A. Potter, B. G. Shaffer. YOUNGSTOWN: Edwin R. Brody. OKLAHOMA-OKLAHOMA CITY: Earl D. McBride.

PENNSYLVANIA-ALLENTOWN: Hope T. M. Ritter. BLOOMSBURG: Harry R. Dailey. SUNBURY: J. Guy Smith. TENNESSEE-JACKSON: Tandy G. Morris. MEMPHIS: Harold L. Williamson. TEXAS-DENISON: T. A. Moorman. LOCKNEY: K. O. Crum. VIRGINIA-FORT BELVOIR: Herbert A. Mahler. WEST VIRGINIA-CHARLESTON: James H. Getzen. WISCONSIN-JUNEAU: Edward C. Ferguson. MILWAUKEE: T. T. Couch. WASHINGTON. D. C.: Sherwyn E. Warren.

CANADA-MONTREAL: Hyman Reisler. ENGLAND-LANCASHIRE: W. P. O'Regan. PANAMA-COLON: Harry Eno. SPAIN-VALENCIA: Antonio Cremades.



## ANNUAL JOINT REPORT

Secretary-Treasurer, Samuel M. Day, M.D.  
Executive Director, W. Harold Parham

This report covers the administrative year 1958-1959 and is submitted as a brief summarization of the many and varied activities of the Secretary-Treasurer and Executive Office during this period. The Association's overall activities have been covered in the Board of Governors and committee reports presented to the House of Delegates where policies are determined.

## SECRETARY-TREASURER

The constitutional Secretary has carried out the many duties required by the Constitution and By-Laws of the Association, which include the initiation of all official correspondence, notification to members of meetings, maintenance of all official records and papers belonging to the Association. The Secretary also attended as many national, state and Association Committee meetings as possible during the year.

Membership of the Association has exceeded all previous records, with a total of over 3,600 members. Less than 100 of this number are retired physicians, and an additional 238 physicians were licensed to practice in Florida early this year. There are now 7,061 licensed Florida physicians and of this number approximately 4,800 reside in Florida.

The report of the Treasurer, including the financial statements, covers the period of March 21, 1958 through December 31, 1958, as the Association changed last year from a fiscal year to the calendar year. It should be noted when considering the income section of the financial statement, the major portion of the 1958 state dues had been collected prior to the beginning of the 1958 fiscal year. The books have been audited by Goodrich & Varndoe, Certified Public Accountants and their Certificate of Audit is incorporated in the statements, which appear at the end of this report.

The Board of Governors approved the proposed budget as prepared by the Secretary-Treasurer and the Executive Director for the 1959 calendar year as follows:

General Expenditures.....	\$39,200
Executive Director's Department.....	15,330
Business Manager's Department.....	15,415
Administrative Department.....	31,551
Public Relations Department.....	12,335
Publications Department.....	67,180
Legislative Department.....	12,771
Building and Grounds.....	11,015
Reserve (5%).....	10,250
	<hr/>
	\$215,047

This was based upon an anticipated income of \$230,000 for the 1959 calendar year as follows:

Dues and entrance fees.....	153,000
Advertising, Journal & Directory sales.....	51,300
Technical Exhibit Space.....	22,000
Interest and Miscellaneous.....	3,700
	<hr/>
	\$230,000

## EXECUTIVE DIRECTOR

The Board of Governors reorganized the management of the executive office on November 1, 1958, eliminating the position of managing director and creating the position of executive director. Mr. W. Harold Parham, who has served for the past ten years as Supervisor, Bureau of Public Relations, Assistant Managing Director and Associate Managing Director, was appointed to this position. In accordance with the recommendations of the new Executive Director, the Board of Governors approved the following administrative structure of the executive office:

1. *Executive Director* has the general responsibility and assignment to carry out the directives of and service to House of Delegates, Board of Governors, Executive Committee, Officers, AMA Delegates; the development, organization, coordination and implementation of the

overall activities of the Association; management of finances, executive office, personnel and headquarters building; supervision of annual convention; administrative liaison with AMA and county medical societies; the rendering of administrative service to Council, Committees on Medical Education and Hospitals, Grievance, and Advisory to Selective Service; and liaison with the State Board of Medical Examiners and the State Board of Health.

2. *Director, Administrative Department.* This position was established and Mrs. Zoe Pack, who has been in the employ of the Association for thirteen years as office manager, was appointed in this capacity. The duties of the Director of this Department are to supervise the department, records, files, rosters, process dues, bookkeeping, clerical personnel, incoming and outgoing mail, interoffice communications, office receptionist and telephone answering, inventory and supply control, maintenance of equipment, auxiliary yearbook; business administration (including exhibit sales income, purchasing and general office management) and building and grounds; and rendering administrative service to the Executive Director, all departments, Committee on Necrology and Woman's Auxiliary to the FMA.

3. *Director, Publications Department.* Mr. Thomas R. Jarvis has been in the Association's employ for eight years and was appointed to this position. The Director of this Department is responsible for supervision of the department, The Journal, Briefs, Directory, Journal library; printing of the programs, handbook, Charter and By-Laws; and procurement of advertising. He also renders administrative service to the Committees on Scientific Work, Medical Postgraduate Course, Blood, Cancer Control, Tuberculosis and Public Health and Venereal Disease control.

4. *Director, Public Relations Department.* Mr. Eugene L. Nixon III, who has been in the Association's employ for four years was appointed to this post. The responsibilities of this position are to supervise the department, press, radio and television relations and programs, publicity, public exhibits, special public relations projects, PR reference library, physician placement; field work, both with county medical societies and news media; and to render administrative service to the Committees on Nursing, Rural Health, Mental Health, Child Health, Maternal Welfare, Poliomyelitis, Liaison with The Bar, Aging, Conservation of Vision, Civil Defense and Disaster, Voluntary Health Agencies, Medical Advisory Committee to the State Department of Public Safety and the School Health Medical Advisory Committee to the State Department of Education and the State Board of Health.

5. *Director, Legislative Department.* This department was created on November 1, 1958 and Mr. Alvin D. James was appointed to the post. The Director's responsibilities are to supervise the department, special legislative activities, COMAH; field work with county medical societies and legislators; and administrative service to the Committee on Legislation and Public Policy and the national legislative key contact physicians and Committees on State Controlled Medical Institutions, Liaison with Labor, Medical Economics, Blue Shield Advisory, Representatives to Industrial Council, Commercial Health Insurance, Veterans Care, Medicare and Fee Schedules, Advisory Committee to the Hospital Service for the Indigent Program, Medical Advisory Committee to the State Department of Public Welfare and Advisory Committee to the State Board of Health for Hospital Licensure.

6. Additional personnel of the Executive Office are Mrs. Ann Ethridge, Mrs. Rita Fitzgerald, Mrs. Elda Harris, Mrs. Mariel Kneuer, Miss June Palmer, Miss Frances Pesce, Mrs. Louise Rader, Mrs. Carolyn Rainey and Mr. Henry L. Maree.

Mr. Harry T. Gray, of the firm Marks, Gray, Yates, Conroy & Gibbs, serves as legal counsel for the Associa-

tion; Mrs. Edith B. Hill, as editorial consultant, and Goodrich & Varnedoe as Certified Public Accountants.

A position of business manager was established and Mr. Ernest R. Gibson, who had been with Association for 12 years and for the past five as Managing Director was offered this position but he chose to accept one with Blue Cross. It is with regret that the Association loses his valuable service.

#### ACTIVITIES

ADMINISTRATIVE ASSISTANCE for the officers, standing and special committees of the Association, maintenance of proper records and files, assistance to county medical societies in planning and implementing programs, and liaison with other national and state medical and lay organizations composed a major portion of the activities of this past year, as in previous years.

FIELD SERVICES comprised one of the major activities of the Executive Director, Public Relations Director and Legislative Director during the past year. Contacts were made with component county societies, legislators, news media and other organizations in the interests of liaison and carrying out the programs of the Association.

THE JOURNAL of the Florida Medical Association for the 12 issues ending with June comprised Volume XLV. There were 46,455 copies printed which is an increase of 3,785 over the previous volume. Attempts have been made to improve both the format and quality of The Journal during the past year. The cost of publishing has increased because the issues are larger, however, offsetting this somewhat has been the increase in revenue from advertising. There has been no increase in the printing cost but there has been an increase in the price of paper.

THE FLORIDA MEDICAL DIRECTORY was compiled and 5,500 copies were printed. Each member of the Association was furnished a complimentary copy.

BRIEFS were prepared and eleven issues sent to all members of the Association during the past year.

ANNUAL MEETING required, as in the past, continuous attention to the details, records and correspondence in connection with the selection of the scientific program, speakers, the technical and scientific exhibitors and other details.

ACCOUNTING AND PURCHASING procedures for the entire organization are maintained on a monthly as well as an annual basis and this year were changed from a manual system to the installation of a Burroughs Machine Accounting System. With this system the posting and crediting of all dues, acknowledgments to members, the AMA and the county societies as well as the banking of same can be handled in one machine operation which saves a great deal of manual labor. Daily balances are also now maintained and statistical data is more readily available.

SPECIAL PROJECTS carried out during the past year consisted primarily of fair exhibits, science fairs, rural health and promotion of the Florida Medical Foundation. The past year saw the largest number of county medical society-sponsored public fair exhibits to date. Eight successful exhibits were staged. The third annual Association awards for medical aptitude were presented in the 1959 State Science Fair held in Tallahassee. Administrative assistance was provided to the Florida Committee on Rural Health and the Florida Medical Foundation.

PHYSICIAN PLACEMENT service of the Association was emphasized this past year. Personal interviews, a large volume of correspondence with physicians seeking locations, field contacts and an increased correspondence with communities seeking medical care are the major aspects of this activity.

LEGISLATION received special emphasis again this year through assisting the Committee on Legislation and Public Policy in carrying out the Association's program regarding national and state legislation and liaison with governmental agencies regarding health services. Administrative assistance was provided to the Governor's Citizens Medical Committee on Health in conducting its study and compiling the final report.

PRESS RELEASES on various phases of the 1958 annual meeting furnished to the state's newspapers and complete press facilities maintained during the meeting, resulted in excellent state coverage. A number of feature stories were carried by Miami papers during the meeting. Special press releases regarding the Association's activities or actions were prepared and distributed during the year as warranted. It is gratifying to note that a high percentage of Association releases were published with little or no alteration by the press.

The Association's popular weekly health column service "Health Topics" now enters its tenth year and plans are underway to modernize the format and conduct an extensive promotion to expand the present mailing list of nearly 100 papers. Assistance was furnished in obtaining Florida correspondents and news sources for the new AMA News.

RADIO AND TELEVISION stations were provided, when feasible, with all press releases furnished to newspapers. AMA transcribed radio programs were promoted and distributed in the state. The series "Health Magazine of the Air" featuring newscaster H. V. Kaltenborn, which began as a monthly series was converted to a weekly basis and distributed to some 30 radio stations. Several AMA films suitable for television, such as The Medicine Man, were scheduled and obtained for stations throughout the state.

MOTION PICTURES provided by the AMA were scheduled and obtained for showing to medical and non-medical groups.

LITERATURE published by the Association and the AMA such as pamphlets, booklets and brochures, were distributed in large quantities to medical societies and other groups, individual physicians and the public at large through waiting rooms, fair exhibits and other activities. The Public Relations reference library was maintained and special packets of materials on various subjects were prepared and furnished to medical societies and individuals upon request.

MEDICARE required a great deal of administrative assistance again this year in processing the correspondence and reports on claims, together with processing of committee minutes and directives.

Dr. Samuel M. Day, Secy.-Treas.  
Florida Medical Association  
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. William Harold Parham, Executive Director of Florida Medical Association, we have examined the books of account, vouchers and other records of the association for the period March 21, 1958 to and including December 31, 1958 and submit herewith our report consisting of:

EXHIBIT "A"—Statement of Financial Position

EXHIBIT "B"—Statement of Income for the Year

SCHEDULE "B-1"—Detail of Expenses shown in the aggregate in Exhibit "B"

EXHIBIT "C"—Schedule of Investments

EXHIBIT "D"—Schedule of Additions to Fixed Assets

We determined that all recorded receipts were deposited to the credit of the association and that the disbursements appeared to be for proper purposes.

The item of accounts receivable, offset by a reserve for deferred income, represents the amount due The Journal by advertisers as of December 31, 1958. We made no attempt to verify these items.

The investments in United States Treasury Bonds were verified by actual count at the safety deposit vault.

Exhibit "B", Income Statement, reflects an excess of Expense over Income in the amount of \$38,584.03. This condition was brought about by the fact that the association elected to close its books as of December 31st, on a calendar year basis, instead of the fiscal year of March 20th, which has obtained in all prior years. By so doing, the short period for this year has been deprived of most



of the income of the association, consisting of dues, which ordinarily is received during the early part of the calendar year. This situation will automatically correct itself for the calendar year 1959.

In our opinion, the accompanying statements present fairly the assets and liabilities of the Florida Medical Association as of December 31, 1958, arising from cash transactions; the income collected and expenses disbursed

by it during the period March 22nd to and including December 31, 1958, consistent with that of the preceding year, with the exception of the income from dues as discussed in the preceding paragraph.

Yours very truly,  
Goodrich & Varnedoe

CHG/d

**EXHIBIT "A"**  
**STATEMENT OF FINANCIAL POSITION**  
**December 31, 1958**

**ASSETS**

**CURRENT**

Checking Accounts:

Atlantic National Bank .....	\$ 24,907.63	
Plus—Deposit in Transit .....	240.00	\$ 25,147.63

Florida National Bank .....	876.04	\$ 26,023.67
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Savings Accounts:

Atlantic National Bank .....	\$ 11,480.30	
Barnett National Bank .....	8,161.00	
Florida National Bank .....	4,080.30	23,721.60

Petty Cash Fund .....	100.00	
Deposit—Universal Travel Plan .....	425.00	\$ 50,270.27

Accounts Receivable:

Due from Journal Advertisers .....	\$ 7,813.66	
Less—Reserve for Deferred Income .....	7,813.66	—0—

Inventory—Stationery, Postage & Printed Matter .....		4,538.85
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TOTAL CURRENT ASSETS .....		\$ 54,809.12
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INVESTMENTS—U. S. Treasury Bond—Per Exhibit "C" .....		16,155.37
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FIXED	COST	ACCUMULATED DEPRECIATION	BOOK VALUE
Land .....	\$ 35,833.31	\$ —	\$ 35,833.31
Buildings .....	122,708.52	8,525.15	114,183.37
Furniture, Fixtures & Equipment .....	42,128.49	16,597.00	25,531.49
	\$200,670.32	\$ 25,122.15	175,548.17
TOTAL ASSETS .....			\$246,512.66

**LIABILITIES AND NET WORTH**

**LIABILITIES**

Due American Medical Association .....		\$ 50.00
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**NET WORTH**

Balance—March 21, 1958 .....		\$285,046.69
Less—Excess of Expense Over Income from Exhibit "B" .....		38,584.03
Balance—December 31, 1958 .....		246,462.66

TOTAL LIABILITIES AND NET WORTH .....		\$246,512.66
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**EXHIBIT "B"**  
**INCOME STATEMENT**  
**For the Period March 21, 1958 Through December 31, 1958**

**INCOME**

Dues—Current .....	\$ 45,480.00	
Dues—Delinquent .....	8,980.00	\$ 54,460.00
Entrance Fees .....		2,790.00
Advertising—Journal .....	\$ 35,451.18	
Advertising—Directory .....	365.00	35,816.18
Journal Subscriptions and Sales .....		385.00
Directory Sales .....		2,167.00



Technical Exhibits .....	14,685.00	
Interest Earned .....	241.60	
Miscellaneous Income .....	668.21	
Medicare Program .....	2,097.76	
TOTAL INCOME .....		\$113,310.75
EXPENSE		
Administrative )	( \$ 62,053.80	
Public Relations )	( 32,974.29	
Publications )	( 49,033.01	
Building Operations )	( 7,833.68	
TOTAL EXPENSE .....		151,894.78
EXCESS EXPENSE OVER INCOME		\$ 38,584.03
—To Exhibit "A" .....		

EXHIBIT "B-1"  
SCHEDULE OF EXPENSES  
For The Period March 21, 1958 Through December 31, 1958

	ADMINIS- TRATIVE	PUBLIC RELATIONS	PUBLICA- TIONS	BUILDING OPER- ATIONS	TOTAL
Payroll Taxes .....	\$ 399.74	\$ 188.36	\$ 130.92	\$ 44.61	\$ 763.63
Postage and Express .....	1,129.25	1,146.44	839.32		3,115.01
Office Supplies .....	876.48	674.58	514.17		2,065.23
Telephone & Telegraph .....	829.76	1,154.72	533.32		2,517.80
Manager's Expense Account .....	1,777.75	4,013.16	203.64		5,994.55
Student A.M.A. ....	300.00				300.00
Legal & Accounting Fees .....	850.00				850.00
Delegates to A.M.A. Convention .....	4,028.40				4,028.40
Maintenance—Office Equipment .....	366.65	160.18	124.30		651.13
Employee's Insurance .....	357.50				357.50
Building Insurance .....				189.74	189.74
Books, Pamphlets, Etc. ....	231.21	506.42	261.90		999.53
Salaries .....	23,566.42	13,993.20	6,466.20	1,980.00	46,005.82
Pension Plan Premium .....	6,668.58	5,519.17	1,354.71		13,542.46
President's Expense Fund .....	1,798.61				1,798.61
Secretary's Expense Fund .....	770.96				770.96
Printing & Engraving .....	911.90	1,053.85	2,101.05		4,066.80
Convention Expense .....	8,129.15				8,129.15
Committee Expense .....	3,658.01				3,658.01
Dues & Fees .....	85.00	100.00			185.00
Miscellaneous Expense .....	412.22	3.00	157.55		572.77
President's Reception .....	1,284.38				1,284.38
Depreciation .....	2,836.83			2,760.93	5,597.76
Special Projects .....		3,614.83			3,614.83
Legislation—Public Policy .....		846.38			846.38
Journal Publishing .....			35,881.45		35,881.45
Directory Expense .....			464.48		464.48
Utilities .....				1,666.94	1,666.94
Janitor's Supplies .....				441.07	441.07
Cost of Heating—Fuel .....				62.80	62.80
Maintenance of Equipment & Plant .....				687.59	687.59
Insurance—Travel .....	785.00				785.00
TOTALS—To Exhibit "B" .....	\$62,053.80	\$32,974.29	\$49,033.01	\$ 7,833.68	\$151,894.78

EXHIBIT "C"  
SCHEDULE OF INVESTMENTS  
December 31, 1958

	BOND No.	RATE OF INTEREST	DATE OF PURCHASE	MATURITY DATE	FACE VALUE	COST
U. S. Treasury Bond .....	15431A	2½%	3/20/54	1962-67	\$1,000.00	\$ 978.44
" " " .....	99158J	2½%	3/20/54	1962-67	5,000.00)	
" " " .....	99159K	2½%	3/20/54	1962-67	5,000.00)	15,176.93
" " " .....	99160L	2½%	3/20/54	1962-67	5,000.00)	
TOTAL INVESTMENTS—To Exhibit "A" .....						\$16,155.37

**EXHIBIT "D"**  
**SCHEDULE OF ADDITIONS TO FIXED ASSET**  
**For The Period March 21, 1958 Through December 31, 1958**

	LAND	BUILDING	FURNITURE FIXTURES & EQUIPMENT	TOTAL
BALANCE—March 21, 1958 . . . . .	\$35,833.31	\$122,708.52	\$35,404.97	\$193,946.80
Additions . . . . .	—0—	—0—	6,723.52	6,723.52
BALANCE—December 31, 1958 . . . . .	\$35,833.31	\$122,708.52	\$42,128.49	\$200,670.32

## REPORT OF THE EDITOR OF THE JOURNAL

Shaler Richardson, M.D.

Some time ago, there was begun a gradual change and, what was hoped, improvement in the appearance of The Journal. More color, pictures, more modern type faces and other ideas were incorporated into the makeup.

The plan was not to remake completely a publication that has served the medical profession in Florida since July 1914. The Journal had progressed with the Association it served. It was founded to be both a leader and a follower. At the time the improvements began, the manner of medical practice was showing change and the progress of the Association was gratifying. The changes in The Journal were begun in order to keep pace.

After the various improvements were underway, at the beginning of the volume just completed, attention was given to the contents. It was found that a good medical journal was being published as far as scientific material was concerned, but that the medical news needed by physicians in a dynamic Association was falling short. The philosophy was no longer true that if news was important it would find its own way into print. There had sprung up mass circulation journals, not wholly scientific, that were providing news and physicians were reading them, laying aside their own Journal. The realization that more medical news was needed came at an opportune time. The Journal was ready for improvements in content.

The first thought in gathering news that would interest physicians was of announcements of state, regional and national medical meetings being held in Florida. A searching of lists of scheduled meetings was begun. Letters were sent requesting information about the program and speakers. The response was gratifying. In most instances, physicians in charge of arrangements prepared complete write-ups and were grateful that The Journal was ready to assist them in publicizing their meetings.

The staff had had experience in certain types of editorials and special articles that would create interest. Physicians who had written for The Journal previously were requested to submit material. They responded graciously.

The Association itself provided news. Committees engaged in tasks of which there was considerable interest were followed for information. In some instances, the Chairman provided the article. There was other activity, particularly among the officers, that provided The Journal with interesting material. Members of the Association were honored for various achievements by their communities, and this made timely reading.

There is sound evidence that members of the Association have become aware of the change in contents and are reading The Journal.

The program of improvement began with appearance

first and then with content, both inside the cover of the publication. For the past two or three months, ideas have been drawn for a new cover.

Since July, 1914, there have been five major changes in the cover, the last one in November, 1948. In a few months, possibly by the time this report is published, the new cover will be ready.

By no means have all the problems been solved, but there is an awareness of them, and the staff of The Journal is striving to build one year upon the other knowing that the foundation is solid.

Volume XLV, ending with the June issue, had 1,500 pages. A total of 46,455 copies was printed. Included in the 12 issues were 45 scientific papers and 47 abstracts.

The entire staff is grateful to the many authors who submitted material for the scientific section. Each paper was read by Dr. James N. Patterson or Dr. Chas. J. Collins, members of the Committee on Publication, before it was referred to me. I am personally grateful to each of them.

Dr. Kenneth A. Morris, Chairman, and Dr. Walter C. Jones were responsible for the Abstracts section, and I am indebted to them.

Each of the Assistant and Associate Editors have cooperated in a most gratifying way. In each issue, there has been at least one article prepared by them. Credit was not given at the time, because being a member of the staff, their name was not published with their work. Sincere appreciation is extended to them: Drs. Webster Merritt and Franz H. Stewart, Assistant Editors; Drs. Louis M. Orr, Joseph J. Lowenthal, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar, George T. Harrell and Homer F. Marsh, Associate Editors. It has been a pleasure to work with this group of physicians and to have had the opportunity of publishing their writings.

Members of the lay staff have had an especial interest in their tasks and have shown by their actions that they enjoyed their work. I am grateful to Mr. Tom Jarvis, Managing Editor, and to Mrs. Louise Rader, Technician, who devote much of their time to publishing The Journal, and to Mrs. Edith B. Hill, Editorial Consultant, who has been ready to do whatever was needed.

This year, my 31st as Editor, has been a period of change, and change is never easy, however, progress comes through change, by stops and starts, and the way of progress is seldom smooth. Through it all, there has been no deviation from our plans, both short and long range, and from our program—to serve the Association as its official spokesman; to explain its activities to its members; to record its history; sometimes to lead, often to follow; and most important, to impart scientific knowledge to the betterment of the practice of the art and the science of medicine in Florida.



## Lest We Forget

During the four weeks just ended, an approximate 7,800 young men and women in this country became full-fledged Doctors of Medicine, receiving their coveted M.D. degree from our universities scattered across the nation. Fifty-nine of these new Doctors were produced in Florida at the University of Miami. Each was granted his degree by his University but, in addition, each became a member of our profession by taking an oath written 2,400 years ago. The fundamental philosophies, morals and ethics are so sound that there has been no need for change through the centuries. I believe that if we study and recite our Oath more often, we will have less difficulty convincing our public of the sincerity of our doctrines. Let us repeat again at this time each year with the new and young members of our profession—

*I swear by Apollo the Physician \* and Aesculapius \* and health \* and all-heal \* and all the gods and goddesses \* that \* according to my ability and judgment \* I will keep this oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents \* to share my substance with him \* and relieve his necessities if required \* to look upon his offspring in the same footing as my own brothers \* and to teach them this art \* if they shall wish to learn it \* without fee or stipulation \* and that by precept \* lecture \* and every other mode of instruction \* I will impart a knowledge of the art to my own sons \* and those of my teachers \* and to disciples bound by a stipulation and oath according to the law of medicine \* but to none others \* I will follow that system of regimen which \* according to my ability and judgment \* I consider for the benefit of my patients \* and abstain from whatever is deleterious and mischievous \* I will give no deadly medicine to anyone if asked \* nor suggest any such counsel \* and in like manner I will not give to a woman a pessary to produce abortion \* with purity and with holiness I will pass my life and practice my art \* I will not cut persons laboring under the stone \* but will leave this to be done by men who are practitioners of this work \* into whatever houses I enter \* I will go into them for the benefit of the sick \* and will abstain from every voluntary act of mischief and corruption \* and further \* from the seduction of females or males \* or freeman and slaves \* whatever \* in connection with my professional practice \* or not in connection with it \* I see or hear \* in the life of men \* which ought not to be spoken of abroad \* I will not divulge \* as reckoning that all such should be kept secret \* while I continue to keep this oath unviolated \* may it be granted to me to enjoy life and the practice of the art \* respected by all men \* in all times \* but should I trespass and violate this oath \* may the reverse be my lot.*

If each of us renews the Oath in his thoughts more frequently, I am sure we will keep our principles truly Hippocratic and not give opportunity for them to be called hypocritic.



# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## 1959 Annual Meeting Draws Largest Member Attendance

The recent convention marked the Eighty-Fifth Annual Meeting of the Florida Medical Association as the most successful ever held in point of member attendance and total registration. Held in an oceanfront setting in the Miami Beach area again this year, the meeting at the Americana Hotel in Bal Harbour on May 2-6 attracted 2,059 registrants. Of 1,201 physicians registered, 1,022 were members, a number exceeding the previous high of 988 in 1957, and 179 were visiting physicians. There were 122 other guests registered, 51 scientific exhibitors and 289 representatives of exhibiting firms. The members of the Woman's Auxiliary and their guests numbered 386. Twenty-five states in addition to Florida and four foreign countries were represented in the registration.

Succeeding Dr. Jere W. Annis of Lakeland in the office of President was Dr. Ralph W. Jack of Miami, and Dr. Leo M. Wachtel of Jacksonville became President-Elect. Dr. Eugene B. Maxwell of Tampa was elected First Vice President, succeeding Dr. S. Carnes Harvard of Brooksville. Dr. Henry L. Harrell of Ocala succeeded Dr.

Walter E. Murphree of Gainesville as Second Vice President, and Dr. Ralph M. Overstreet Jr. of West Palm Beach was elected Third Vice President to succeed Dr. Joseph W. Douglas of Pensacola. Dr. Samuel M. Day of Jacksonville was re-elected Secretary-Treasurer.

The Association's 1960 meeting will be held in Jacksonville, where the new Robert Meyer Hotel and the nearby George Washington Hotel will offer adequate facilities. Of the few dates available, April 8 to 12 was selected. This early date does not schedule the meeting too close to the annual meeting of the American Medical Association to be held in Miami Beach next June.

The House of Delegates convened for its first session on Sunday afternoon, May 3. Featured were a stimulating address by President Annis, published in this issue of The Journal, and election of delegates to the House of Delegates of the American Medical Association. Dr. Louis M. Orr of Orlando, who resigned as a delegate because of his official position in the parent organization, was recognized by President Annis as "our most distinguished native son, and most

distinguished member of this organization, the man who has been elected to Medicine's highest honor, Dr. Louis M. Orr, President-Elect of the American Medical Association."

Elected to serve until Dec. 31, 1959 as a replacement for Dr. Orr and to serve as a delegate for a two year period beginning Jan. 1, 1960 was Dr. Meredith Mallory of Orlando. Dr. Eugene G. Peek Jr. of Ocala was elected as the alternate to Dr. Mallory for the two year term. Since the Association was this year allotted another delegate, Dr. Burns A. Dobbins Jr. of Fort Lauderdale was elected the fourth delegate to serve for the remainder of this year and for a two year term beginning Jan. 1, 1960. Dr. Walter E. Murphree was elected his alternate, and Dr. Madison R. Pope of Tampa was elected the alternate to Dr. Francis T. Holland to succeed Dr. Murphree, who resigned when nominated for the post of fourth delegate.

At this session the Honorable O. B. McEwan, President of The Florida Bar, was recognized and he addressed the House briefly. He commended the Association for establishing a Standing Committee on Medical Testimony. Also, he advised that The Florida Bar has established an official grievance committee in each of the judicial circuits of the state and he invited any member of the medical profession to avail himself of the services of the appropriate grievance committee, should the occasion arise.

Also at this session, John F. Mason Jr. of the College of Medicine of the University of Florida and Charles B. Farmer of the University of Miami School of Medicine, representatives of their schools to the national convention of the Student American Medical Association, presented impressive reports of the meeting just concluded in Chicago. They expressed due appreciation to the Association for defraying their expenses.

At the General Session on Monday morning, May 3, the delegates were privileged to hear an address by the President's guest, the distinguished Dr. Irvine H. Page of Cleveland, Professor of Medicine, Frank E. Bunts Educational Institute, and Director of Research, Cleveland Clinic Foundation. Dr. Page chose for his subject "Ideas on the Mechanism and Treatment of Hypertension."

The Association was fortunate to have as a guest Dr. F. J. L. Blasingame of Chicago, Executive Vice President of the American Medical Association. He spoke at this session on "A.M.A. Reorganization."

Three general scientific addresses by outstanding authorities were also a feature of the General Session. Dr. Ethan Allan Brown of Boston presented an address on "The Dilemma of Modern Therapeutics." Dr. John J. Farrell of Miami spoke on "Surgical Therapeutics of the Adrenals," and Dr. L. Maxwell Lockie Sr. of Buffalo discussed "Use of Gold in the Treatment of Rheumatoid Arthritis."

Following the custom of the last two years, the scientific program was presented in its entirety in a morning and an afternoon session on Tuesday, May 5. The program covered a wide range of subjects, including a symposium on "Cardiovascular Problems" and one on "Accidents."

At its second meeting on Wednesday morning, May 6, the House acted on the recommendations of the five reference committees and elected officers for the ensuing year.

With regard to health and education, the House endorsed the principles and policies of the State Tuberculosis Board and of the Florida State Board of Health pertaining to "destructive legislation . . . recommended in the current session of the Legislature" which would severely cripple progress in the control of tuberculosis in Florida. The House also expressed opposition to a bill introduced in the current legislature to prohibit fluoridation of public water supplies. A resolution calling upon the Association to urge state assistance to cancer patients under the Hospital Services for the Indigent Program without the prerequisite of tumor clinic approval was disapproved by the Committee on Cancer Control, and its action was concurred in by the House.

In matters of public policy, the Committee on Conservation of Vision, acting in an advisory capacity to the State Board of Education and the Florida State Board of Health, won approval of the House for its plan to install a uniform, medically supervised program of eye screening in all the elementary schools of the state, the pilot plan put into effect in Polk County in September 1958 serving as a pattern. A major principle outlined by the Committee in its report was that "all parts of the school health program, including vision, should be the responsibility of the County Health Officer and administered by him with the supervision and advice of the local medical society."

The report of the Committee on Medical Education and Hospitals showed that the total amount contributed to the American Medical





Dr. Ralph W. Jack, Miami  
President



Dr. Leo M. Wachtel, Jacksonville  
President-Elect

Education Foundation in 1958 from Florida was \$6,978 from 243 contributors, an increase over 1957 but still leaving Florida fifth in the South in amount contributed. In adopting the report, the House gave approval to the recommendation that a voluntary contribution of \$7.50 per member per year be made to this especially needy cause and that the funds be channeled through the Florida Medical Foundation, with the Foundation sending a statement on Nov. 1, 1959 to each member of the Association as a reminder.

House approval was given also to the recommendations of the Medical Schools Liaison Subcommittee regarding an income level for patients which would enable them to be admitted to the



Dr. Samuel M. Day, Jacksonville  
Secretary-Treasurer



Dr. Henry L. Harrell, Ocala, Second Vice President; Dr. Eugene B. Maxwell, Tampa, First Vice President, and Dr. Ralph M. Overstreet Jr., West Palm Beach, Third Vice President, (left to right)

University of Florida Teaching Hospital for a hospital charge but no professional fee, and a \$150 "package deal" for obstetric patients. Determination of indigency will now be made by the respective county agency responsible, and patients not so certified will be subject to the usual hospital charges and professional fees set by the physician. Also, in place of the present tentative patient income classification schedule, financial information on individual patients to aid physicians in setting their fees will be furnished by the business office of the College of Medicine. In addition, all nonindigent obstetric patients will now be subject to the usual hospital charges and professional fees for complete care instead of the fixed charge of \$150.

The Committee on Medical Economics reported progress in expanding and improving the Association's insurance program. It recommended enthusiastically the establishment of an investment plan for members of the Association to be known as the Florida Medical Association Investment Trust and to be operated in two divisions: (1) a restricted retirement trust drawn to meet the requirements of the Keogh Bill, H.R. 10, as well as Treasury regulations to qualify for self-employed tax deferment, and (2) an investment trust open for members to which contributions could be made in amounts with minimum contributions in multiples of \$50 with 1,000 as a minimum number of participants, and with no tax deferment. The House acted favorably on the report of this Committee.

The House approved the report of the Committee on Representatives to Industrial Council, which included a proposed revision of fee schedules for medical, surgical, radiologic and related services in the implementation of The Florida Workmen's Compensation Act, and granted the Committee authority to represent the Association in the negotiations. It was expected that a date for a preliminary hearing before the Industrial Commission would be set in May.

The Committee on Nursing reported the joint efforts of the Association and the State Department of Education to salvage the Practical Nurse Training Program. Some 11 counties are now conducting one year preparatory courses, and over 1,500 practical nurses have graduated from these courses. If the state legislature adopts the recommendation of the Interim Committee on Education of the State Legislature to abolish state funds for Adult Vocational Education, this pro-

gram would be "greatly handicapped and perhaps eliminated."

With regard to administration, the report of the Board of Governors exemplifies the many ramifications of its activities during a busy year of constructive work. Attention focuses on the newly revised Charter and By-Laws approved by the House as amended after some discussion. A special committee spent more than two years in its preparation, incorporating much needed changes. A new feature of particular interest is provision for a Speaker of the House of Delegates to be elected by the House, who may succeed himself only once. There is provision also for a Vice Speaker, who likewise may succeed himself only once. The Charter and By-Laws now go to the component societies for ratification.

The House gave its approval to the report of the Board's special committee on contract medicine. This committee was assigned the task of re-evaluating the Association's policy regarding members of the Association engaging in contract medicine and of recommending policies. The report recommended reaffirmation by the Association of its policy that the Principles of Medical Ethics and Opinions of the Judicial Council of the American Medical Association shall be binding upon all of its members and made specific reference to Principle 6: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care." To implement this principle, a strong statement of policy and principles was included in the report.

On recommendation of the Council, the House approved granting requests for formation of two separate component medical societies to be known as the Highlands County Medical Society and the Charlotte County Medical Society. In consequence, the name of the DeSoto-Hardee-Highlands-Glades County Medical Society is changed to DeSoto-Hardee-Glades County Medical Society and the name of the Lee-Charlotte-Hendry County Medical Society becomes Lee-Hendry County Medical Society.

In its report, the Advisory Committee to Blue Shield announced that the new Type A Blue Shield contract is now available to the public. Describing it as "fair and equitable as far as fees are concerned, and . . . a wonderful thing for the public if they can only understand," the

Committee urged all members to do everything possible to make it successful. Attention was directed to the new participating physicians manual which is also now available. It gives full information concerning Blue Shield and lists the fee schedules of the new Type A and the present Type J and Type F contracts.

After some discussion, the recommendation of the Medicare Mediation Committee that the Association continue under Medicare was approved with the provision that the government, in the opinion of the Committee, show material progress in working out an insurance program such as the Committee presented before the next annual meeting of the House of Delegates. If satisfactory progress to this end is not made by that time, the Association will no longer continue under the Medicare program.

The report of the Committee on Legislation and Public Policy reviewed the many important activities of this key Committee during the year at the state and national levels and directed attention to the establishment of the Legislative Department at the time of the recent reorganization of the Executive Office. The Committee was pleased to report that the study undertaken by the Citizens Medical Committee on Health, appointed by Governor Collins, was completed

and presented to him. Those recommendations included as part of the Governor's legislative program have the support of the Association.

This final session of the Eighty-Fifth Annual Meeting closed with the institution of two new customs. After Dr. Annis had presented to Dr. Jack a gavel engraved with his name and year of service and had introduced him as the new President, his first official act was to present a Past President's Button and Certificate of Honor to Dr. Annis. On behalf of the Association, President Jack then presented to Mrs. Annis the portrait of Dr. Annis which had adorned the Board Room in the offices of the Florida Medical Association throughout the year of his presidency. He thereby initiated a practice that becomes a gracious courtesy to the wives of future presidents.

The second innovation was a Certificate of Merit, established by adoption of a resolution previously presented by Dr. Jack, to be awarded to members for exceptionally distinguished service. As his next official act President Jack awarded the first Certificate of Merit to Dr. Edward Jelks of Jacksonville.

Before adjournment, Dr. Annis addressed the House in executive session.

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## Dr. Louis M. Orr Accedes to Presidency Of American Medical Association

As this issue of The Journal goes to press, some 30,000 persons are converging on Atlantic City, N. J., the "Medical Mecca" of America for the next two weeks. Of more than 20 meetings of national medical organizations being held there, the major one is the 108th Annual Meeting of the American Medical Association, opening on Monday, June 8, and continuing through Friday, June 12. This meeting will draw approximately 15,000 physicians and 18,000 other persons, including physicians' wives, interns, residents, medical students, exhibitors, nurses, and technicians.

Of paramount interest to Floridians and particularly to members of the Florida Medical Association is the inauguration of Dr. Louis M. Orr of Orlando as the 113th president of the American Medical Association at this meeting. The ceremony is scheduled to take place on



Dr. Orr



Tuesday night, June 9, in the ballroom of Convention Hall. It will be followed by a president's reception and ball.

The subject of Dr. Orr's inaugural address is "This We Believe." He will outline the principles of medicine, democracy, and faith by which American physicians live.

Dr. Orr has long been a participant in A.M.A. activities. Since 1946 he has represented the Florida Medical Association with great distinction in the House of Delegates of the national organization and has served as vice speaker of that policy-making body. He has also served as chairman of the federal medical services com-

mittee, as an ex officio member of the Council on Constitution and By-Laws, and as a member of the Council on Medical Service.

The Florida Medical Association plans to have a hospitality room open from 5 to 7 p.m. on Monday and Tuesday, June 8 and 9, at the Traymore Hotel, headquarters for the meeting, and all Association members in attendance have been invited to be on hand to assist with the hospitality to the other states. The Association will give a reception honoring Dr. and Mrs. Orr from 5:30 to 7:30 p.m. on Wednesday, June 10, at the Traymore Hotel.

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## Certificate of Merit. New Association Award Dr. Edward Jelks Is First Recipient

In this day of crying need for leadership in all walks of life, it is peculiarly fitting to render honor to whom honor is due for conspicuously able leadership. Through the 85 years of its existence the Florida Medical Association has been fortunate in the leadership that has brought it into the large place which it holds today within the profession of Medicine. The complexities of the times, the phenomenal progress of Medicine, the growing socioeconomic problems confronting the profession, the constantly increasing demands upon physicians and the remarkable growth of the Association all place an ever higher premium on true leadership within its ranks.

It is therefore particularly appropriate that at the Annual Meeting of the Association last May, by adoption of a resolution presented by Dr. Ralph W. Jack, President-Elect, the House of Delegates created an award designated a Certificate of Merit. As stated on the certificate, its purpose is to recognize "exceptional and outstanding service to the Association, to the medical profession and to the public, as laid down in the Principles of Medical Ethics." The resolution provides that this award be made only from time to time as occasion warrants rather than annually or at any fixed interval. It stipulates also that the selection of a member to be so honored shall be made by the House of Delegates from nominations made by the Board of Governors.



Dr. Edward Jelks of Jacksonville is escorted to the platform to receive the first Certificate of Honor by Dr. Homer L. Pearson Jr. of Miami (left) and Dr. Louis M. Orr of Orlando.

No more appropriate choice of a first recipient of the Certificate of Merit could have been made than that of Dr. Edward Jelks of Jacksonville for no more dedicated and untiring servant of medicine could be found. For more than four decades he has served the Association in countless capacities from member to President and representative to the House of Delegates of the American Medical Association, from Liaison on Public Relations of the Board of Governors to President of the Florida Medical Foundation. In the words of the resolution granting him this highest honor, the award was bestowed upon this "courtly gentleman of Medicine and exemplary member of this Association, in recognition of his outstanding ability, his unswerving loyalty, his complete dedication, his prodigal expenditure of time and talents at great personal sacrifice in the interests of the Association and of organized medicine as a whole, and his innumerable contributions to the art, the science and the socioeconomic progress of Medicine in Florida and in the nation."

As one of the first official acts of his administration, President Jack, at his special request, was privileged to make the presentation of the award after Dr. Jelks was escorted to the platform by Dr. Louis M. Orr and Dr. Homer L. Pearson Jr. Characteristically, Dr. Jelks accepted the Certificate of Merit "not as an honor to one member of the Florida Medical Association, but as recognition that one member over a period of years had the privilege of working with hundreds, perhaps thousands of members . . . and with members of our home office to the end that we might all achieve the objectives of the Florida Medical Association." He told the House that he now possessed three documents which brought him unlimited satisfaction and gratitude—a letter received 50 years ago announcing his acceptance by the medical school of his choice, a license issued eight years later authorizing a life partnership, and the Certificate of Merit just awarded him. He assured the delegates that he would ever treasure the certificate "with the enthusiasm and appreciation of an ardent bibliophile who secures a very rare first edition of a great classic."

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### **Florida Medical Association Golf Tournament**

The annual Florida Medical Association Golf Tournament was held May 4-5 at the LaGorce Country Club in the Miami area during the Association's annual meeting at Bal Harbour.

The Duval County Medical Society Trophy for low net was awarded to Dr. Lester A. Russin of Miami Beach, and the Orlando Loving Cup for low gross to Dr. Robert G. Gilbert of Coral Gables. In addition each winner was awarded a box of golf balls by Eaton Laboratories.

Dr. Rene A. Torrado of North Miami served as chairman of the Golf Committee for the annual meeting. Assisting him were Drs. John H. Tanous and Lester A. Russin of Miami Beach.

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### **Seminar Schedule College of Medicine University of Florida**

The Division of Postgraduate Education of the College of Medicine of the University of Florida announces its schedule of Seminars for the next fiscal year. The list follows:

Seminar in Internal Medicine—Neurology  
University of Florida, Gainesville  
September 24-26, 1959

Seminar in Surgery  
University of Florida, Gainesville  
January 14-16, 1960

Seminar in Pediatrics  
University of Florida, Gainesville  
February 11-13, 1960

Seminar in Obstetrics and Gynecology  
University of Florida, Gainesville  
February 25-27, 1960

Others:

Seminar in Diabetes Mellitus—Florida Diabetes Association  
Balmoral Hotel, Miami Beach  
October 29-30, 1959

For further information address the Division of Postgraduate Education, College of Medicine, The J. Hillis Miller Health Center, University of Florida, Gainesville.

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### **Newspaper Notes Dr. Annis' President Page Messages**

The men whose job is to write the news, daily recording a report of events as they happen while the presses wait impatiently for the last line to be added, are known for the sincerity of their compliments, and for the fact that when a compliment is given it is well deserved. It is, therefore, meaningful to note an editorial in the Lakeland Ledger of Wednesday, May 6, 1959, entitled "A Literary Doctor" relating one facet some members of the Association may have

missed of a physician to whom many compliments have come during the year just ended.

"Lakeland's Dr. Jere W. Annis has come to the end of his year as president of the Florida Medical Association. The gavel passed from him to the new president at the annual convention held at Miami Beach during the past four days.

"During the year he has served, he has gained additional prestige not only as a doctor of medicine but also as one who has exceptional literary talent.

"This has been evident in the message he has written each month for the president's page of the Journal of the Florida Medical Association. These thoughtful messages of compactness and polish have reflected a degree of scholarship that has stimulated much favorable comment among doctors in Florida and beyond. His "Ides of March" message was one of special merit.

"Another facet of his versatility has been noted as he has gone about the state addressing various medical and civic groups.

"All in all, he has had a good year as president of Florida's doctors, and it is likely that still more recognition in the medical field will be coming to him. Lakeland, as a medical center of increasing importance, is proud to have come to a Lakeland doctor the distinction which the state presidency confers."

### Recordings of Cardiovascular Seminar Available on Loan

The Northeast Florida Heart Association announces that tape recordings of the Sixth Annual Cardiovascular Seminar held in Jacksonville on February 19 through 21, 1959 are available on loan without charge to physicians of Florida. The tape recordings represent approximately nine hours that have been especially selected and edited from the entire 15 hour session. These nine hours are divided into five sections; the average section runs about two hours. The sections are as follows:

Section 1. Three lectures by Dr. Samuel A. Levine of Harvard University

- a. Errors in the care of cardiac patients
- b. Types of medical thinking
- c. Some puzzling points about coronary heart disease

Section 2. Three lectures by Dr. Irving S. Wright of Cornell University

- a. Recent advances in the use of anticoagulants

b. Medicine in Europe

c. Strokes, diagnosis and treatment

#### Section 3. Two panel discussions

a. Cor Pulmonale

Moderator: Dr. Max Michael Jr., Jacksonville

Panel—Dr. Levine, Dr. Victor McKusick of Johns Hopkins University, Dr. A. G. Morrow of National Heart Institute and Dr. A. E. Anderson of Jacksonville

b. Atherosclerosis

Moderator: Dr. Mason Romaine III, Jacksonville

Panel—Drs. Levine, McKusick, Morrow and Wright

#### Section 4. Panel Discussion and Condensation

a. Panel on Cardiovascular Surgery

Moderator: Dr. Arthur R. Nelson, Jacksonville

Panel—Drs. McKusick, Morrow, William J. Taylor and Myron W. Wheat Jr., Gainesville, and Roy M. Baker, Jacksonville

b. Condensations by Dr. Nelson of addresses on cardiovascular surgery by Drs. Morrow and Wheat

#### Section 5. A lecture entitled "Subacute Bacterial Endocarditis" by Dr. Michael

Doctors who are interested in borrowing these tapes may do so by requesting them from Mr. James Geiger, Audio-visual Library, Florida State Board of Health, P. O. Box 210, Jacksonville. The tapes may be borrowed one section at a time for a period of one week. When one section has been returned another section may be ordered by the same physician.

For further information, write to Dr. Daniel R. Usdin, 3960 Oak Street, Jacksonville.

EIGHTY-SIXTH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

April 8-12, 1960, Jacksonville

Headquarters: Robert Meyer Hotel



## OTHERS ARE SAYING

### Doctor's Time

"Make your minutes count and the harvest of your days will be assured. Remember that time is money," said Benjamin Franklin in the formative years of our nation. Doctors should be especially familiar with that statement because knowledge and time are their livelihood, and when either wanes their lot is imperiled.

Some of our lay friends apparently are not cognizant of this fact since they minimize the value of medical time contributed to charity and then insist that doctors should give cash and time to organizations in amounts comparable to business men. Pressure is again being brought to bear on physicians of our community to contribute a specific sum of money for equipment, "the use of which will benefit the doctor most." Since the lawyers do not furnish the courthouses and ministers do not build churches, we are at a loss to understand why doctors are the scapegoats and are expected to be major underwriters of hospitals, charitable organizations and other worthwhile projects related to the practice of medicine. If an individual doctor thinks enough of a project and wishes to contribute a large or small sum, that is commendable but it is his affair. But if pressures are brought to bear for designated sums and disparaging remarks are made about the lack of generosity of the doctors, then it is time that the true facts be presented.

As long as we give generously our time and talents to hospitals, patients and charitable organizations, we need make no apologies. It is true that some doctors contribute much, some are not given the opportunity to contribute a great deal, and a few give little, if anything, to anyone. My words today are in defense of the giver, not the parasites who drain the profession in more ways than this one. The selfish deserve no credit for statistics that follow, and likewise, our workers deserve no share of the scorn and pressures that may be aimed at the drones.

Duval County has not had the benefit of detailed studies of doctor's time spent with charity patients, but enough statistical surveys have been made elsewhere to get a reasonable idea of the time given. In 1947, MEDICAL ECONOMICS found that six hours a week were donated to charity patients by the *average* independent physician, amounting to 10 per cent of his *total*

working hours. This did not include office charity, lay and medical teaching, volunteer work for voluntary and government organizations, professional courtesy or prolonged case reductions. Eighty-eight per cent of independent physicians did charity work to some extent. A few years later a Florida County found that local doctors contributed time equal in money value to the total community chest budget.

In 1955, New Hampshire revealed that 12 per cent of the individual doctor's time went to charity, providing in money value \$65 weekly or approximately \$3500 annually. This brought a provocative total of \$2,096,640 per year statewide, or \$5,760 daily or \$4 worth of free medical care every minute.

In 1956, Tulsa, a city with Duval's present doctor census (350), collected the conservative figure in excess of \$500,000 contributed annually, figured on a basis of only two hours weekly at \$15 per hour. The society's president called attention to the fact that this service meant time away from the doctor's practice from which his revenue is produced. Therefore, there is no income from other sources for the time lost in this worthwhile manner. Also, it means work at any hour of the day or night that the patient may demand and less time with family and friends; time that is far too short already.

Recently, the state of Tennessee, with a comparable number of doctors to Florida (3450), found that their average doctor provided more than \$4,000 per year in free medical service, amounting to more than \$9,000,000 annually, in addition to \$2,992,000 donated in cash to charity.

Though unrecognized and unappreciated by the "fund drivers," these time contributions are all the more valuable because they are likewise unrecognized by income taxers. No allowances are made, though "time" is a physician's money and his productive span may be shorter than that of an oil well and other more natural resources which are given very special tax considerations. If Florida doctors see the sad day that they are reimbursed for charitable efforts by government, it will take many more dollars to do the job than these conservative studies indicate. Also, medicine is the only profession or business other than the ministry which does not make a sizable profit from government.

Voluntary and charitable organizations could hardly survive without the aid of conscientious doctors who advise and counsel them without

charge, and who carry out many of the therapies for which they exist, without charge. These ever mushrooming organizations usually have a medical problem as their reason for existence so it seems natural to them that the doctors who are called upon to help build their groups are also requested to play a major part in their financing. A recent article in Harper's magazine showed 60 groups in one county soliciting funds, practically all of which had medical connotations. Nineteen were for the blind, seven for disabled veterans, six for crippled and five for cancer.

Some doctors have even found themselves beneath a hospital tax levied against them for each patient they admitted to that hospital. The serious ramifications of this extreme approach were recognized by the House of Delegates of the A.M.A. at San Francisco and it condemned such actions and requested that doctors not participate in them.

It has been suggested that labor, business and other elements of our population who supposedly are dissatisfied with our charitable contributions in the operation of our hospitals might join programs of similar nature. It would involve the rendering of all services by their representatives, free of charge, in all departments where charitable care is involved. Certainly this could mean economy in government and in voluntary agencies, and improved care of our indigent.

It was stated appropriately by James Bryce in 1947, "Medicine is the only profession that labors incessantly to destroy the reason for its own existence." Who really enjoys the benefits of the hospitals, the clinics and the charitable services from which the doctors are said to profit? It is the patient who benefits. The life span of the doctor is *not* the one that has increased at an amazing rate in recent decades. The average income of the physician is *not* out of line with others when compared to earlier years. The amount one accumulates in a lifetime from medicine is *not* as great as in years past. Unfortunately, this ironic twist is causing many recent medical graduates to be more jealous of their time and to be less generous with their money. How long can we criticize this trend when we see the charitable attitude rewarded by repeated attempts at socialization as well as criticism from our friends?

Dr. Osler has said that medicine is "a jealous goddess." It should be. The profession of the dedicated doctor comes first and there should be no differentiation between charity and pay

patients if the challenge of disease exists. Let it always be so.

*Sam M. Day, M.D.*

*Monthly Bulletin*

*Duval County Medical Society*

*May, 1959.*

BLUE



SHIELD

## Fourteenth Annual Meeting of Active Members

May 4, 1959, Miami Beach

The Fourteenth Annual Meeting of Active Members of Blue Shield of Florida, Inc., was held during the Eighty-Fifth Annual Meeting of the Florida Medical Association at the Americana Hotel in Miami Beach, Florida. The seated House of Delegates of the Association compose the majority of the active membership of Blue Shield.

Dr. Russell B. Carson, President, made the following report.

Blue Shield of Florida is now concluding another successful year with this Annual Meeting. Again it is my pleasure to have served you as President, and to bring you this message of the activities of the past twelve months. Accomplishments by the Board of Directors and the Staff of Blue Shield have been many during the past year, but they represent the cumulative efforts of previous Boards and previous Committees who have been working over a period of several years. It is my feeling that more accomplishments have been concluded during the past year than in any year for quite some time.

At the last Annual Meeting of Blue Shield no new business requiring further action was brought out. The activities on which I will report now have been those of the Board of Directors and the Committees appointed by the Board. As usual, the financial position of Blue Shield will be reported to you by the Treasurer, and a review of the over-all status of Blue Shield of Florida will be given by the Executive Director, Mr. H. A. Schroder.

The Board of Directors of Blue Shield has had regular quarterly meetings as provided for in the By-Laws, and in addition to the regular quarterly meetings, two special meetings were held, one for organizational purposes and election of officers, which followed the last Annual Meeting; and the other a special instructional meeting which was held September 20-21, 1958. In addition to these regular Board meetings, the Executive Committee of the Board has met on an average of once between each Board meeting. This is brought to your attention so that you may be informed of the contribution made, not only by the physician members of the Board, who contribute their time to the preservation and advancement of the Plan, but more particularly to the contribution made by the lay members of the Board for the many hours of valuable time they contribute. These lay members are Mr. William Hollis, of Lakeland; Mr. C. DeWitt Miller, of Orlando, President of the Blue Cross Plan; Mr. H. Plant Osborne, of Jacksonville, who has also served as our legal advisor since the origin of Blue Shield; Mr. Carl G. Rose, of Ocala; Mr. Arthur Saarinen, of Fort Lauderdale; and Hon. Ben C. Willis, Judge of Leon County Circuit Court, Tallahassee.

During the past year there has been constituted a liaison committee between Blue Cross and Blue Shield



## Underweight Children Gain and Retain Weight with Nilevar<sup>®</sup>

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

**Anorexia and "Weight Lag" Study**—Brown, Libo and Nussbaum have reported\* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

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Research in the Service of Medicine.

\*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



consisting of three members of the Board of Directors of each of these corporations. The purpose of this liaison committee is to preserve an open line of communication between the two corporations to promote prompt discussion and solution of common problems. A few further words regarding this committee may be in order so that the active membership may better understand the relationship between the two corporations. As you know, Blue Cross and Blue Shield are separately constituted corporations, each established by the enabling act of the State Legislature for specific purposes. For convenience and for economy the two corporations have seen fit to cooperate as far as housing, personnel, sales organization, and cooperative planning are concerned. Financially the two corporations are separate. There is a working agreement in which Blue Cross agrees to furnish space, personnel, and the other facilities necessary to the conduct of the business of Blue Shield. The expenses of this operation are prorated between the two corporations.

Because at various times throughout the last few years some persons have expressed concern over the fact that Blue Shield does not own outright specific properties and have separate personnel, a special study of the situation was undertaken by the joint Blue Cross-Blue Shield liaison committee. When the matter was discussed with the members of Blue Cross, it was the feeling that Blue Cross would be very happy to share the ownership of the land, office buildings, furniture, fixtures, personnel, and other jointly used items. There was no hesitancy on the part of Blue Cross in its willingness to have Blue Shield enter into an ownership partnership. After a very careful and thorough study of the present working agreement with Blue Cross, which in every respect has been satisfactory for the two corporations during the past years, it was the conclusion of both the study group and the Board of Directors of Blue Shield, that the present working agreement was a very advantageous one to Blue Shield and that nothing should be done to disturb this working agreement. It should be pointed out that some of the advantages to Blue Shield are:

A saving in rent, more efficient use of personnel, greater advertising force by joint activity, closer coordination of sales activities in producing "package coverage," and especially in the fact that at the present time it is of advantage to have one's finances in liquid form rather than fixed in real estate or property.

Also under consideration by this joint liaison committee were such problems as the further support of COMAH by the two corporations, and consideration of the contract between Blue Cross and Blue Shield which permitted the administration of the Medicare program. Here Florida Blue Shield acted as the fiscal administrator appointed by the government, with Blue Cross serving as a subcontractor, and it was agreed by both Executive Committees and Boards that the subcontract agreement approved by our general counsel should continue in operation.

First and foremost has been the final production and very recent distribution of the new Type "A" Contract which is now a marketable contract and ready for sale to subscribers of Florida. Along with the contract has gone the production of the Participating Physician's Manual, which is now available to all the Participating Physicians in the State. This will be recognized as a monumental piece of work resulting from the untiring efforts of the Committee of 17, and the New Contracts Committee of Blue Shield, together with many hours of work by the Executive Committee and the full Board of Blue Shield. Many thousands of dollars have been spent on the production of this new contract, and, as you are all aware, it has taken approximately three years to accumulate the data; of meetings by all segments of the medical profession, and by the cooperative efforts of the entire physician population of the State to finally make possible the production of the new contract. In the meantime, while the Type "A" Contract has been in the process of development it is probably already partially outmoded; however, it is recognized by everyone as a tremendous improvement, and a step in the right direction. It is hoped that the people of the State of Florida will accept this contract with enthusiasm, and that they can afford to purchase it in sufficient numbers to practically replace the previous contracts. As has been said so many times in the past, we have been operating under an indemnity type contract which provided the service features for a very minimal number of people of this State. The old contracts long since have outlived their usefulness to the subscribers, and we physicians of the State must not permit such a lag in future developments, but must keep abreast with the changing times.

During the past year we have developed a Professional Relations Department in the Blue Shield Staff for the purpose of assisting physicians and their employees in matters concerning the Plan. The objectives of the Department are to acquaint new physicians in Florida with the Florida Blue Shield Plan, to assist their secretaries in the understanding of the contracts and claim forms, and to assist subscribers who have problems relating to Blue Shield Contract payments. This Department's personnel, headed by Mr. Joe Stansell, is available at any time to appear before county society meetings, county insurance or economic committees, to call upon individual doctors, or to prepare material for county medical publications. The Department was originated to serve the profession and we hope you will use it liberally. If it can be of service please write or call the home office in Jacksonville.

The Board of Blue Shield has now agreed to embark upon a plan to cooperate with other Blue Shield Plans in the servicing of a National Contract which can provide coverage for groups whose members are located in more than one Plan area or state.

As was mentioned in my report to you last year, another one of the serious problems which faces medicine at this time is that of providing adequate care for the senior age population, which is particularly heavy in our State of Florida. Thus far we have been slow in getting something concrete developed to offer this subscriber public. More energetic efforts along this line have

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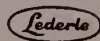
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been urged by the American Medical Association at the annual interim meeting held in Minneapolis in December, and Blue Shield has offered its facilities, and desires to cooperate in every way possible. It is hoped that out of the House of Delegates of this Annual Meeting of the Florida Medical Association will come enabling resolutions instructing Blue Shield as to the type and extent of coverage desired for the senior age citizens of Florida, and requesting Blue Shield to develop and service such a contract as will put us in a position to protect our senior citizens, to maintain our free practice of medicine, and to thwart the efforts at further federalization of our ever-shrinking horizon. It is recognized that the new tack being taken by the Forand Bill, which was introduced in February of this year, places emphasis on providing hospital care for the senior citizens. At the present time it is minimizing the physician care for these persons. We cannot sit back with a feeling of security that this is not an election year and no definite legislative act will be passed during the present session of Congress, because if we are going to be in a position to claim that we have an answer to the problem, that solution must be one which is actively and successfully working, and not one which is simply on the drawing board.

Another problem of considerable importance is that of developing major medical coverage to supplement the improved Type "A" basic contract which we now have available. It has been impossible to develop a major medical coverage while we were still working on the more basic contract, but now during the coming year it should be possible to provide a more complete package of medical care, which seems to be desired by a large portion of the buying public. Great care will have to be exercised in the development of this program since experience is accumulating to the effect that major medical coverage has in some instances been a very expensive experiment to those who pioneered in this field.

A further look into the future needs of your Blue Shield program would suggest the possibility of developing a sliding scale service ceiling and fee schedule, which

would keep your Blue Shield in constant balance with the changing economic conditions of the nation. I would like to see authorization given to the Board of Blue Shield to maintain this sliding scale relationship between the cost of living, the cost of medical care, and the provisions for supplying that medical care by automatically lowering or elevating the service ceiling and fee schedule in keeping with the changing times.

It is hoped that the Committee of 17 will be continued as in the past, as an independent committee, consisting of a group of thoroughly conversant individuals whose prime interest is in keeping Blue Shield a progressive, useful instrument of the medical profession. I hope that the force and influence and respect which the past Committees of 17 have had will not be reduced or jeopardized, because it has helped make one of the strongest Blue Shields in the South.


I wish to express my most sincere thanks to the members of the Board of Blue Shield for their assistance and support during the past year. My thanks go especially to our Executive Director, Mr. H. A. Schroder, for his most valuable assistance. Also, I wish to convey to the entire employee staff of Blue Shield the appreciation of the officers and Board for another successful year by Blue Shield. It has been a pleasure to serve you, the Active Membership.

Then Dr. Floyd K. Hurt, Treasurer, using charts, illustrated how the Blue Shield dollar was spent during 1958. Dr. Hurt reported the distribution of the Blue Shield dollar, the number of claims paid, the growth in membership and as a matter of information, how the Blue Cross dollar was spent.

Mr. H. A. Schroder, Executive Director, then read his report to the membership. Mr. Schroder indicated that, of the seventy-one Blue Shield Plans, we now rank thirteenth in size and further explained the changes that have come about in the operation of the Corporation in 1958.

There being no nominations from the floor, the slate of candidates for Directors was then voted upon. Three new Directors, Drs. Henry J. Babers Jr., Gainesville, and W. Dean Steward, Orlando, and Mr. H. P. Osborne Jr., Jacksonville, were elected to the Board. Mr. H. P. Osborne Sr., Jacksonville, was elected to the position of Honorary Director.

The Board of Directors for 1959 is now composed of the following physicians and lay members. The officers are Drs. Russell B. Carson, President; George S. Palmer, Vice-President; Jere W. Annis, Vice-President; John T. Stage, Secretary; Floyd K. Hurt, Treasurer; Samuel M. Day, Ass't Treasurer; and Mr. H. A. Schroder, Ass't Secretary. Other Doctors of Medicine serving on the Board for 1959 are Drs. Henry J. Babers Jr., Norval M. Marr, John D. Milton, William C. Roberts, Hunter B. Rogers, W. Dean Steward, and Millard White. Lay members now serving on the Board are Messrs. William Hollis, C. DeWitt Miller, H. P. Osborne Jr., Carl G. Rose, Arthur Saarinen, and The Honorable Ben C. Willis.



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
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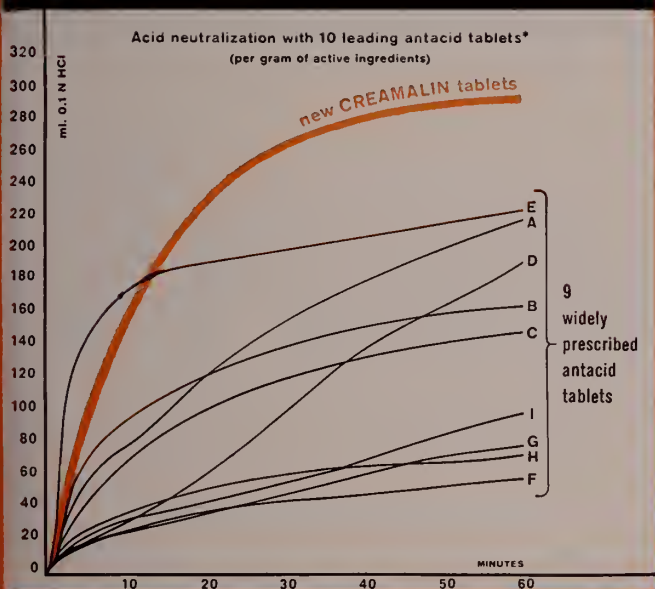


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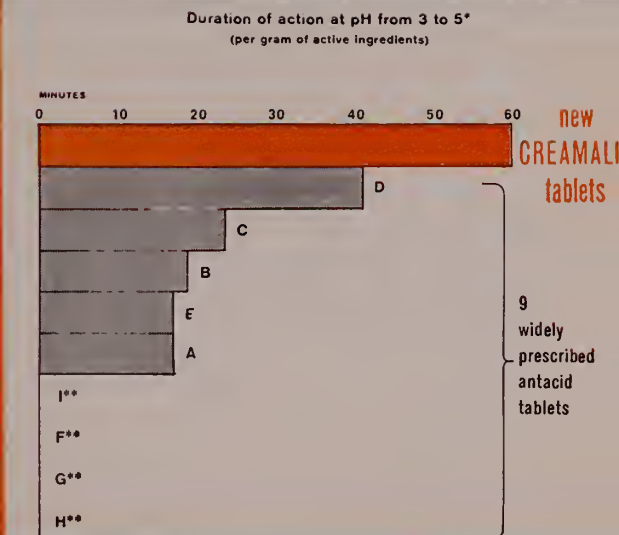
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\*Hinkkel, E. T. Jr., Fisher, and Tainter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

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## STATE NEWS ITEMS

Dr. Hyman J. Roberts of West Palm Beach has been honored as one of the five outstanding young men of Florida for the year 1958. Dr. Roberts' book "Difficult Diagnosis" is in its fourth printing in less than eight months following its initial announcement. The Italian printing will be released shortly.

Dr. Hugh A. Carithers of Jacksonville was a recent speaker at the meeting of the Jacksonville-Duval County Safety Council. The title of his address was "Murder Is No Mystery" dealing with accidents among young children

Dr. Irwin S. Leinbach of St. Petersburg has presented a "Rehabilitation Bookshelf" to Dr. Ivo Popovic, Professor of Surgery at the University of Belgrade, as a contribution to international rehabilitation education. The presentation took place at Washington, D.C., while Dr. Popovic was in the United States for a six months study tour sponsored by the International Cooperation Administration. Dr. Leinbach is a director of the United States Committee of the International Society for the Welfare of Cripples and is a member of the committee planning the Society's Eighth World Congress.

Dr. Lester R. Dragstedt will become Research Professor of Surgery at the College of Medicine, University of Florida, August 1 following his retirement as Chairman of the Department of Surgery at the School of Medicine, University of Chicago.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, and Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, appeared on the program of the 9th annual convention of The Florida Bar held at Miami Beach, May 21-23.

Dr. Joseph C. Rush of Dunedin addressed the Tampa Local Meeting of the Florida Chemical Society May 21. His topic was "Radioactive Isotopes in Clinical Medicine."

Dr. Daniel H. Rowe of West Palm Beach attended the recent meeting of the American College of Obstetricians and Gynecologists held in Atlantic City.

A Sports Medicine Congress will be held in conjunction with the 3rd Pan American Games scheduled for Chicago August 27-September 7. The Congress will be held September 1-2 on the Chicago campus of Northwestern University and will feature experts in the fields of athletic training, care of injuries, cardiovascular effects of sports activity and many other facets of the sports medicine field. Dr. Paul Dudley White of Boston is one of the featured speakers.

Dr. M. Jay Flipse of Miami and Dr. Alexander Libow of Miami Beach participated in the program of the Silver Anniversary Meeting of the American College of Chest Physicians held June 3-7 at Atlantic City. Dr. Flipse served as a discussion leader at a Fireside Conference on "Pulmonary Edema," and also as a member of the panel which discussed "Medical vs. Surgical Treatment of Coronary Heart Disease" at a

*(Continued on Page 120)*



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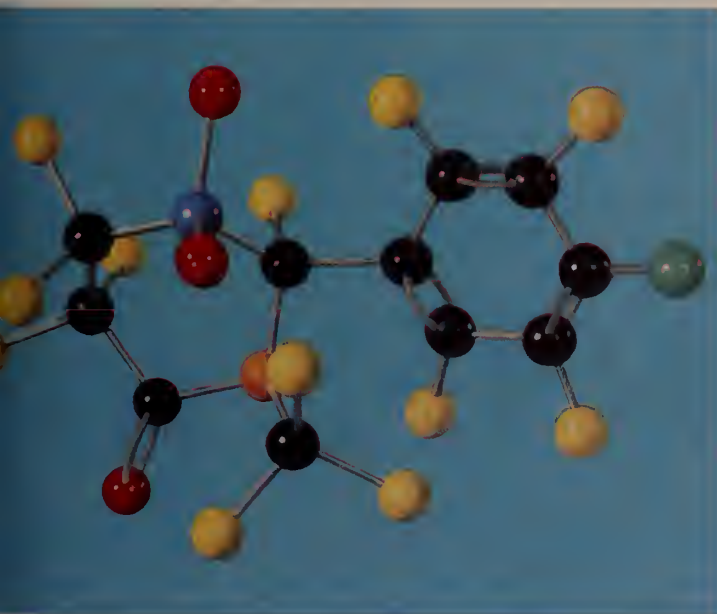
*Remarkable relief from*  
**LOW BACK PAIN**  
*and*  
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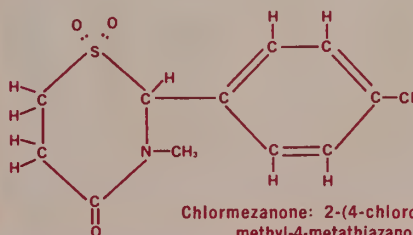
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*...Equally effective as a* **TRANQUILIZER**

\* **tran-qui-lax-ant** (tran'kwi-lak'sant) [ < L. *tranquillus*, quiet; L. *laxare*, to loosen, as the muscles ]



Trancopal, a major development of Winthrop research, is a new, orally administered non-hypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



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Clinical studies of over 4400 patients by 105 physicians<sup>1</sup> proved Trancopal remarkably effective in musculoskeletal conditions, anxiety and tension states.

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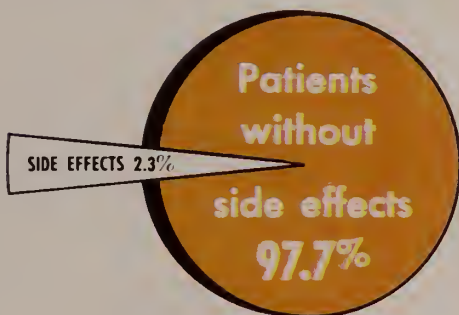
By relieving muscle spasm and pain, Trancopal permits early and active exercise and physical therapy to accomplish maximal benefits for rapid recovery.

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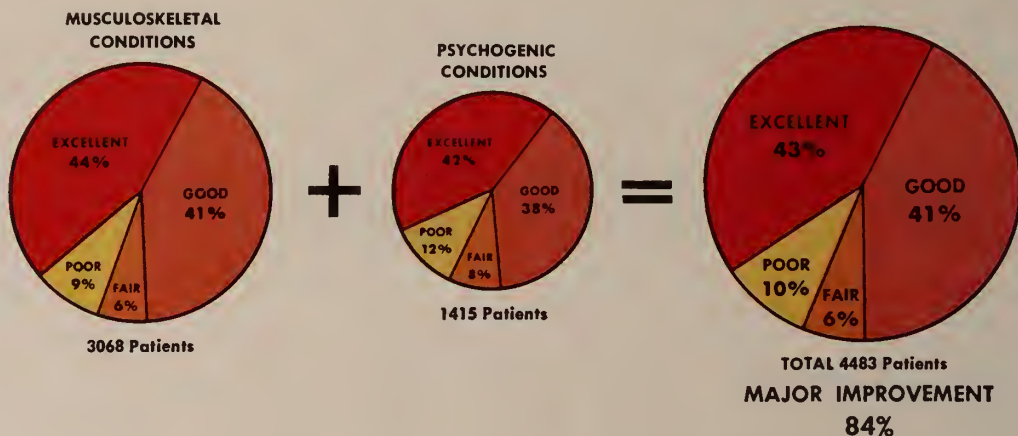
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Premenstrual tension	Alcoholism

**Supplied:** Trancopal Caplets® (scored) 100 mg., bottles of 100.

**References:** 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E.: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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see  
Page 666

# avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4, 5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2, 4, 5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

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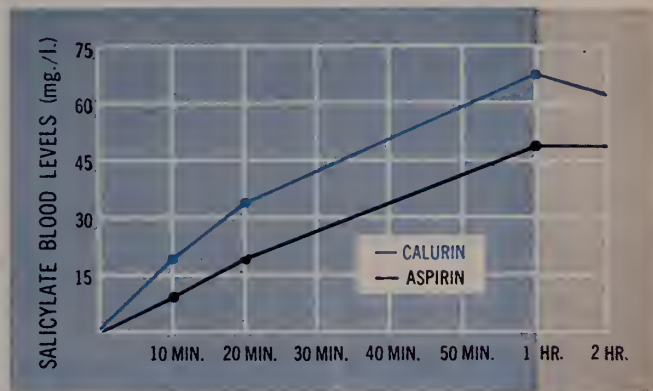
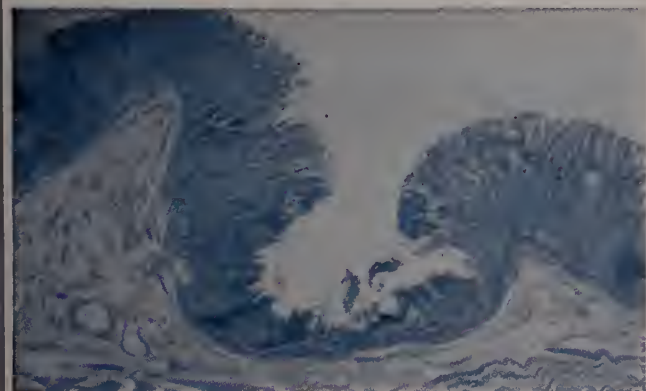
Regular aspirin crystals 24 hours after being mixed into water.



Calurin crystals in solution one minute after being mixed into water.

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**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, *Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif.*, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

\* TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska





*New hope for fetal salvage*

# Delalutin

SQUIBB HYDROXYPROGESTERONE CAPROATE

*improved progestational therapy*

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.<sup>1</sup> Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

- 37% of 73 pregnancies were carried to term without progestational therapy
- 64% of 42 pregnancies were salvaged by progesterone
- 83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.

108 (76%) of 142 babies of this birth weight survived without progestational therapy.

16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.

A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

*Administration and Dosage:* Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

*Supply:* Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

*References:* 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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*Squibb Quality—the Priceless Ingredient*

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(Continued from Page 114)

Round Table Luncheon. Dr. Libow presented the report of the Committee on Non-Surgical and Drug Therapy at an open forum of the Council of Research.

The International College of Surgeons has announced that its fourth around-the-world postgraduate refresher clinic will begin October 10 with departure that date by plane from San Francisco. Meetings have been arranged by the Sections in Tokyo, Hong Kong, Bangkok, Tel Aviv, Istanbul and Athens. Information may be obtained from the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was one of the featured speakers on the program of the 193rd annual meeting of the Medical Society of New Jersey held the last of April in Atlantic City. Dr. Orr's topic for an address at the second session of the House of Delegates was "Our Major League." At the dinner-dance honoring the president of the Society and his wife, Dr. Orr presented greetings from the American Medical Association.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, was presented the distinguished service award by the Florida Chapter of the Arthritis and Rheumatism Foundation at the Annual State Arthritis Conference held May 5 at Miami Beach. Dr. Annis was selected to receive the award for cooperation given to the Chapter by the Florida Medical Association under his presidency.

The Ninth Annual Postgraduate Obstetric-Pediatric Seminar is scheduled for Thursday, Friday and Saturday, August 20-22, at the Ellinor Village Country Club at Daytona Beach, according to announcement by Dr. E. Frank McCall of Jacksonville, chairman of the Committee on Maternal Welfare of the Florida Medical Association, who is serving as program chairman.

The Seminar is jointly sponsored by the state health departments of South Carolina, Georgia, Florida and Alabama, and the Maternal Welfare Committees of the medical associations of these states. It is approved by the American Academy of General Practice for 15 hours in Category I. There is no registration fee. Entertainment features include Hawaiian buffet, swimming and golf.



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with low incidence of sensitivity reactions . . .  
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An excellent salt replacement  
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*Contains potassium chloride,  
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2 oz. shakers and  
8 oz. bottles

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*Assures patient's  
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The wonderful moment when a fifteen-footer drops in . . .

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GREAT PUTT! A real honey. One like *that* makes the whole day worth while. Now relax . . . sit back with a good cold glass of beer. It'll quench your thirst—sure. But much more. Beer's bright, wonderful, alive. Nothing's more rewarding—and it really picks you up, too.

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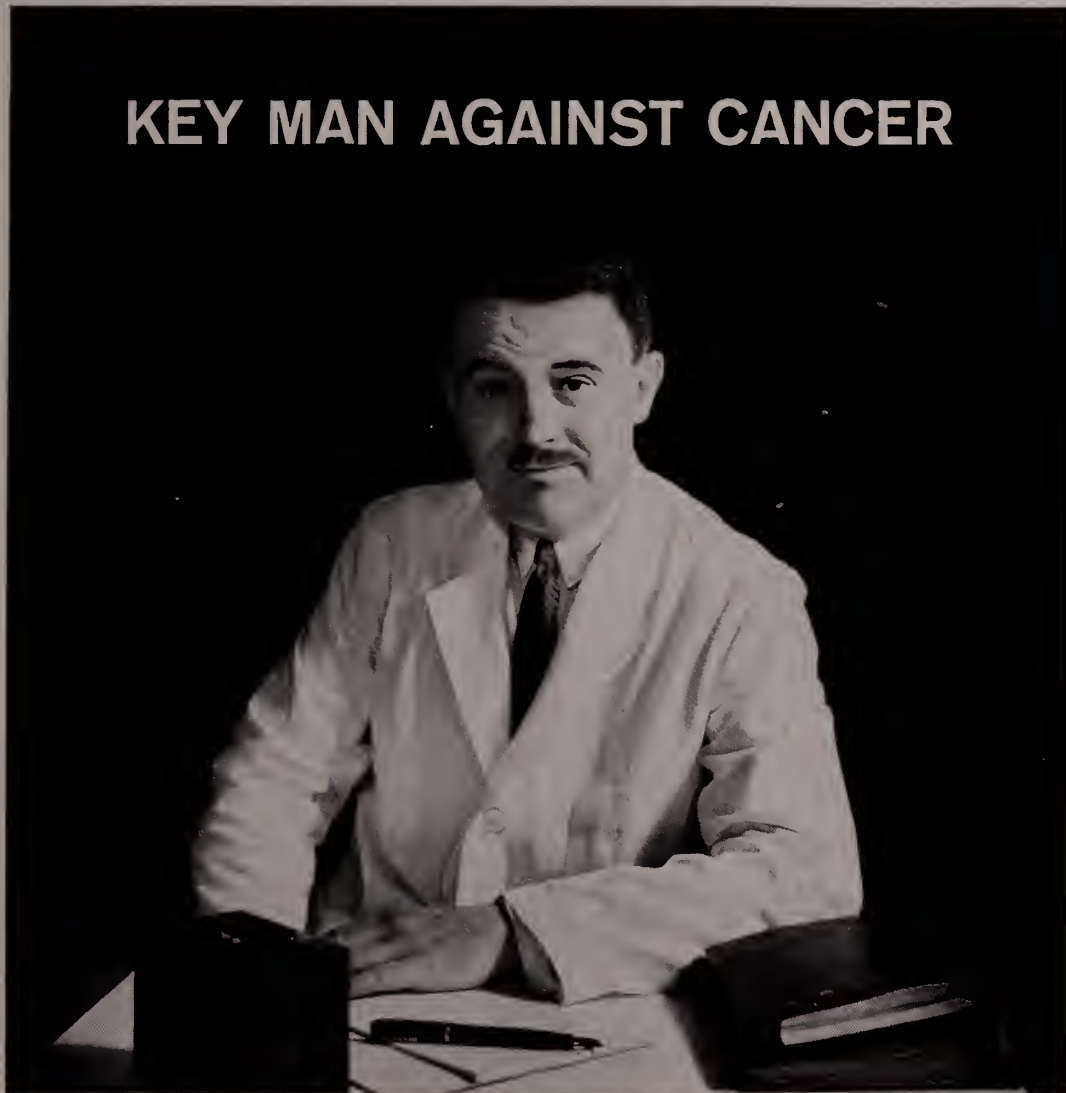


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**YOUR OFFICE, DOCTOR,** is the "cancer detection center" which we urge all adults to visit once a year, and where early diagnosis of cancer can help save many thousands of lives. It is upon you that we largely rely for the carrying out of many aspects of our education, research and service programs. As members of our Boards of Directors — on the National, Division and Unit levels — it is your thinking and your guidance which are such vital factors in creating and executing our policies and programs.

You, of course, are concerned with all the ills affecting the human body. The American Cancer Society deals specifically with cancer. But our mutual concern — the tie that binds us inextricably—is the saving of human lives. Through your efforts, we may soon say—"one out of every two cancer patients is being saved." Indeed, with your help, cancer will one day no longer be a major threat.

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*... a new way  
to relieve pain  
and stiffness  
in muscles  
and joints*

INDICATED IN:

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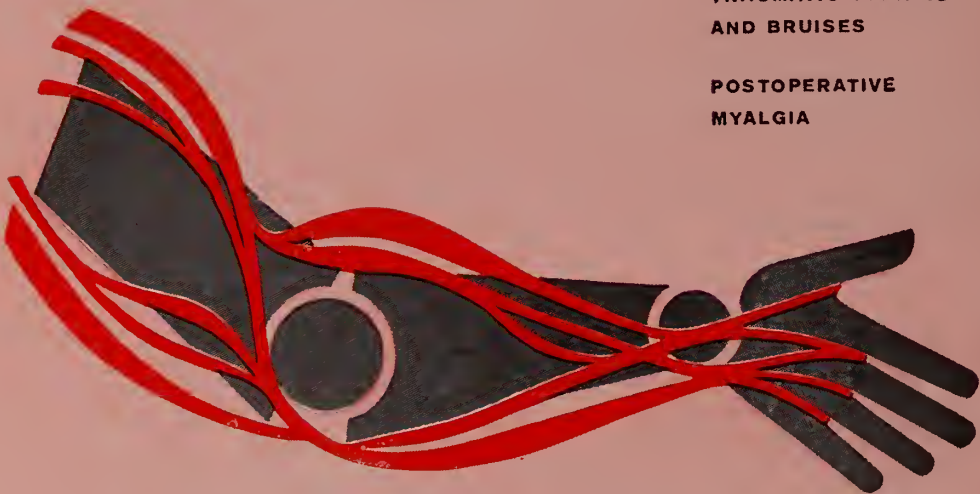
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TRAUMATIC STRAINS  
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- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMATIC pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

# SOMA<sup>TM</sup>

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- More specific than salicylates
- Less drastic than steroids
- More effective than muscle relaxants

**SOMA** has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

**ACTS FAST.** Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

**NOTABLY SAFE.** Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

**EASY TO USE.** Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

**SUPPLIED:** Bottles of 50 white sugar-coated 350 mg. tablets.

*Literature and samples on request.*



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## COMPONENT SOCIETY NOTES

### Dade

Col. George M. Knauf, director of the Occupational Health Research Laboratory at the Air Force Missile Test Center, Patrick Air Force Base, was featured speaker at the June meeting of the Dade County Medical Association. The title of his address was "Medical Aspects of Missile Operations."

### Duval

Dr. Paul V. Reinartz of Jacksonville was one of the principal speakers at the June meeting of the Duval County Medical Society. Dr. Reinartz led a discussion on "Medical-Insurance Relations in Florida" as a representative of the United States Health Insurance Council.

### Lake

Members of the Lake County Medical Society held their May meeting at the Fountain Inn in Eustis in conjunction with the Lake County Den-

tal Society. Dr. Frank Mangum, county dental officer, was principal speaker and reported the results of a recent dental survey among children in the first six grades of Lake County schools.

### Madison

The Madison County Medical Society has paid 100 per cent of its state dues for 1959.

### Putnam

The Putnam County Medical Society has paid 100 per cent of its state dues for 1959.

### St. Johns

The St. Johns County Medical Society has paid 100 per cent of its state dues for 1959.

### Walton-Okaloosa

The Walton-Okaloosa County Medical Society has paid 100 per cent of its state dues for 1959.

### Washington-Holmes

The Washington-Holmes County Medical Society has paid 100 per cent of its state dues for 1959.

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### Burdick EK-III Dual-Speed Electrocardiograph



The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

#### Special Features:

Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design. Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.



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# Antivert<sup>®</sup> stops



# VERTIGO

*Each ANTIVERT tablet contains:*

Meclizine (12.5 mg.)—most effective anti-histaminic to control vestibular dysfunction.<sup>1</sup>

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.<sup>2,3</sup>

### Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."<sup>2</sup>

*Indications:* Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

*Dosage:* one tablet before each meal.

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*References:* 1. Charles, C. M.: *Geriatrics* 2:110 (March) 1956. 2. Menger, H. C.: *Clin. Med.* 4:313 (March) 1957. 3. Shuster, B. H.: *M. Clin. North America* 40:1787 (Nov.) 1956.



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# RESEARCH:

## key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have

been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.

The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.



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*in vaginitis*

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*destroys all **3** principal pathogens*

Whether vaginitis is caused by *Trichomonas*, *Monilia* or *Hemophilus vaginalis*—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR<sup>®</sup> brand of nifuroxime, the *established* specific trichomonacide FUROXONE<sup>®</sup> brand of furazolidone and the *combined* actions of both against *Hemophilus vaginalis*.

**1.** Office insufflation once weekly of the Powder (MICOFUR [anti-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued home use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).



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brings relief IN SECONDS, FOR HOURS*

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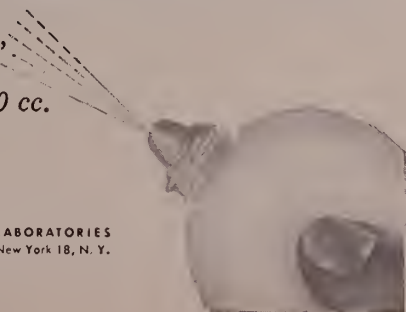
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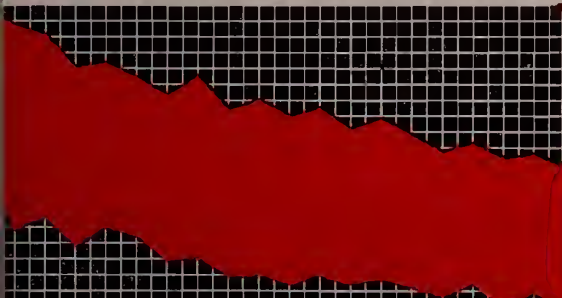




## HYDRODIURIL alone



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## HYDROPRES

much more effective  
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- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
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- With HYDROPRES, dietary salt may be liberalized.
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## HYDROPRES-25

25 mg. HYDRODIURIL, 0.125 mg. reserpine.  
One tablet one to four times a day.

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If the patient is receiving ganglion blocking drugs or hydralazine,  
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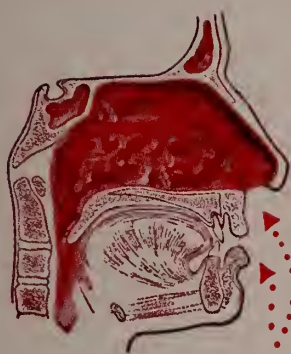
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These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.<sup>3</sup> *This is not enough*; by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

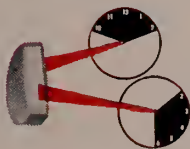
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*References:* 1. Sheldon, J. M.: Postgrad. Med. 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.F.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Each TRIAMINIC timed-release tablet provides:

Phenylpropanolamine HCl.....	50 mg.
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*Also available:* TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to 1/4 Triaminic Tablet or 1/2 Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.



running noses



and open stuffed noses orally



## OBITUARIES

### Ben Martin McClosky

Dr. Ben Martin McClosky of Tampa died on Dec. 10, 1958, after a brief illness. He was 58 years of age.

A native of Ohio, Dr. McClosky was born in Cleveland in 1901. He received his medical training at the Ohio State University College of Medicine, where he was graduated in 1927. After serving an internship at the Gordon Keller Hospital in Tampa, he located in that city and served as city physician for 12 years. Later, he served two years as county physician and then engaged in private practice as a general practitioner. He was a member of the staff of Tampa General Hospital, St. Joseph's Hospital, Centro Asturiano Hospital and Tampa Negro Hospital. Locally, he was a member of the fraternal orders of Odd Fellows, Moose and Elks, and was also a member of the American Legion and the Civitan Club.

Dr. McClosky was a member of the Hillsborough County Medical Association and had held membership in the Florida Medical Association since 1934. He was also a member of the Ameri-

can Medical Association and the American Academy of General Practice.

Surviving are the widow, Mrs. Ruth L. McClosky, a son, Richard McClosky, a daughter, Miss Marilyn Sue McClosky, a brother, A. J. McClosky, two grandchildren, Richard and Ronja McClosky, and a nephew, Dr. Paul J. McClosky, all of Tampa.

## BIRTHS AND DEATHS

### Births

Dr. and Mrs. Alvaro Vargas of Hialeah announce the birth of a daughter, Annette, on April 9, 1959.

Dr. and Mrs. Walter R. Lambert of Miami announce the birth of twin daughters, Mari Merci and Maria Elena, on May 5, 1959.

Dr. and Mrs. Stephen P. Gyland Jr. of Jacksonville announce the birth of a daughter, Carol Jean, on May 5, 1959.

### Deaths — Members

Bernstein, Clarence, Orlando	April 23, 1959
Ross, William E., Jacksonville	May 16, 1959
Sullivan, Rcsa L., Pensacola	April 4, 1959
Weber, Henry C., Drexel Hill, Pa.	October 30, 1958

### Deaths — Other Doctors

Cennell, Isee Lee, Jacksonville	February 14, 1959
Stanford, James Butt, Dania	January 29, 1959
Thomas, Efton Jewel, Miami Beach	February 4, 1959
Wilheit, Fred L., Ft. Lauderdale	December 30, 1958

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Each PERCODAN\* Tablet contains 4.50 mg. dihydrohydroxycodine hydrochloride, 0.38 mg. dihydrohydroxycodine terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

**AND THE PAIN  
WENT AWAY FAST**



*Literature? Write*  
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\*U.S. Pat. 2,628,185

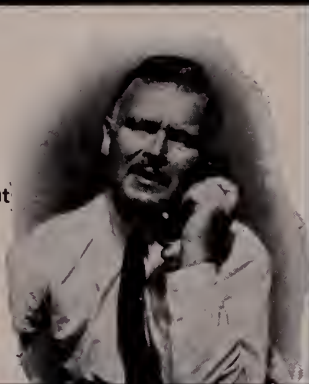
Reaching for 9B shoes and other top shelf sizes is no joke... it gave me a terrible kink in my back.



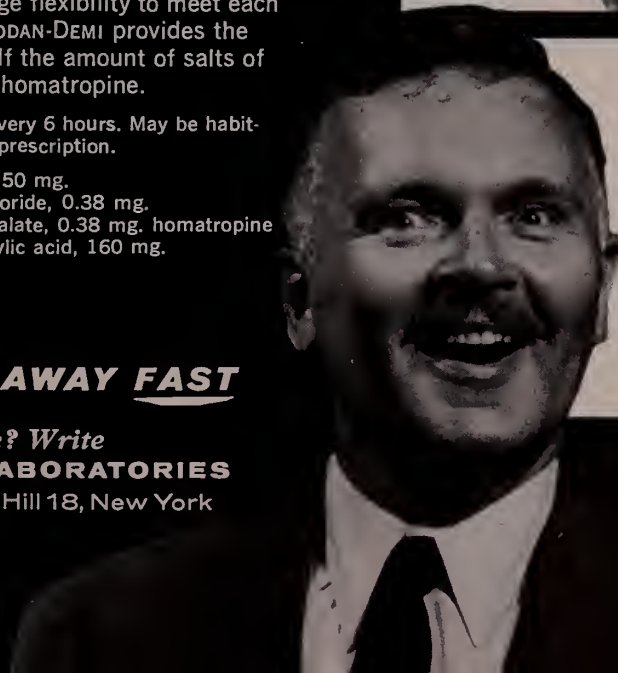
Before the day was over, I could hardly stoop to push a shoehorn.



I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!



# BONADOXIN<sup>®</sup>

(tablets and drops)

## STOPS STOPS STOPS MORNING SICKNESS

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Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance" rarely "zero." BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antiveriginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.



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Dosage:

under 6 months . . . . . 0.5 cc.

6 months to 2 years . . . . . 1.5 to 2 cc.

2 to 6 years . . . 3 cc.

adults and children over 6 . . . . . 1 tsp. (5 cc.)

2 or 3 times daily, on the tongue, in fruit juice or water

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.; West, J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Coding, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1956. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.



## NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alpert, Barnett B., Hollywood  
Andrejek, Arthur R., South Miami  
Blount, Robert E., Leesburg  
Bonifield, Harold F., Floral City  
Dobelle, Martin, Melbourne  
Dominguez, Jose R., Daytona Beach  
Elchos, Theodore G., Panama City  
Faber, John H., Fort Lauderdale  
Gibson, James W., Coral Gables  
Gordon, Minerva, Miami Beach  
Harris, Stephen M., Miami  
Harrison, William V., Ormond Beach  
Maultsby, Maxie C. Jr. (Col.), Cocoa  
Mulford, William A., Daytona Beach  
Norris, James E. C. (Col.), Melbourne  
Parent, Charles-Henri, Fort Lauderdale  
Parker, Harold E., Crestview  
Peddy, Robert B., Titusville  
Read, William L., Winter Haven  
White, Joseph W., Fort Lauderdale  
Williamson, Douglas E., Sarasota

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and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basis and pull-out step are included.

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chronic, primary or  
secondary fibrositis — or even  
early rheumatoid arthritis

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relief; aids restoration of function . . . wide range  
of application including the entire fibrositis syn-  
drome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-  
dosage corticosteroid therapy—

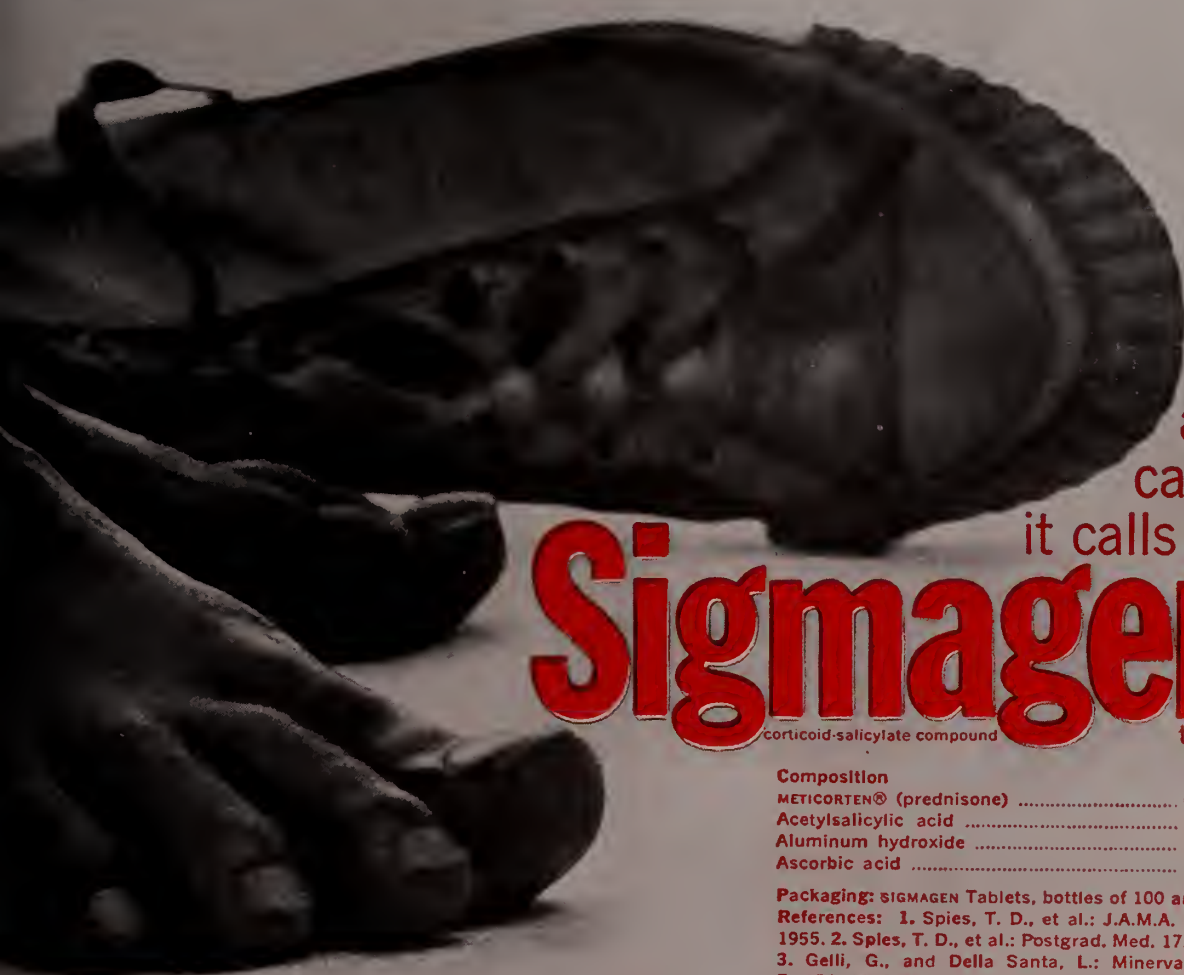
much less likelihood of treatment-interrupting  
side effects<sup>1-6</sup> . . . reduces possibility of residual  
injury . . . simple, flexible dosage schedule

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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"ability to decide correctly has increased, while the illlogical response to anxiety has diminished."

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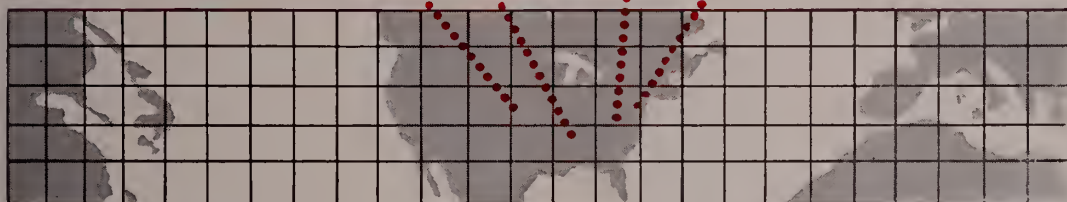
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."

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For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

- Supplied: Tablets, bottles of 100. Syrup, pint bottles.
- Parenteral Solution, 10 cc. multiple-dose vials.
- References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1634 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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### A Message from the President

It is with a great deal of pleasure that I am able to send my first brief message to the Florida Medical Association via the Florida Medical Journal. We are happy to be an Auxiliary to such a wonderful Association.

From time to time in this column we will remind you what the Auxiliary is doing. There are many projects approved by our Advisory Committee, and most of our efforts are exerted in three directions, namely; the recruiting of nurses and other workers in the allied medical fields; contributions to the American Medical Education Fund; the selling of Today's Health magazine; stressing safety in all we do; assisting in legislation any way we can. We are never idle. This year as President of the Auxiliary I will stress the part of our code which states we are in existence to "promote friendly relations between the physicians and their families."

I should like to quote part of my inaugural address: "I feel that our greatest field of Public Relations lies within our own organization. Have you had a doctor and his wife over for dinner recently? Not one you associate with often, but a newcomer to your city, or one not in your particular group? Have you personally called on the new members of your auxiliary? Or called them on the phone?"

"Are you always a one woman auxiliary to your own husband? Recently a cartoon appeared in which a wife was pushing her half awake husband out the front door. Explaining to her neighbor she said, 'He's all right, once I get him into orbit!' Are you doing all you can to get your husband into orbit and keeping him there?"

The demands upon your wife's time are great. She is constantly in the "limelight." She is expected to be a leader in her community and its affairs. Whatever she does is a credit to the Auxiliary, and therefore, a credit to you. Encourage her in any of these endeavors that she has the time and capacity to undertake.



**In response to  
innumerable requests  
from dermatologists**

**Winthrop Laboratories  
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# TRIQUIN®

**FOR LUPUS ERYTHEMATOSUS AND  
LIGHT-SENSITIVITY ERUPTIONS**

## **WHAT IT IS:**

A combination of Atabrine® hydrochloride 25 mg., Aralen® phosphate 65 mg. and Plaquenil® sulfate 50 mg.

## **WHAT IT'S FOR:**

Treatment of lupus erythematosus (chronic discoid type) and polymorphic light eruptions (light-sensitivity eruptions, solar urticaria or dermatitis).

## **HOW IT ACTS:**

Each of the three components produces beneficial response in lupus erythematosus and light-sensitivity eruptions. Since the dose of each of the Triquin components is very low, overall toxicity is reduced and clinical tolerance improved. Furthermore, the three components appear to act synergistically.

## **HOW SUPPLIED:**

Triquin tablets in bottles of 100, sold on prescription only.

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## **DOSAGE:**

**Lupus.** Average initial adult dose, 1 or 2 tablets after meals and at bedtime. Dosage should be reduced gradually at two week intervals to 1 or 2 daily.

**Light-Sensitivity Eruptions.** Average initial adult dose, 1 tablet after breakfast and lunch. May be reduced after several weeks to maintenance dosage of 1 tablet daily.

You can help your wife to be a better Auxiliary member by encouraging her participation in Auxiliary projects. The statistics here in the State of Florida prove that the Future Nurses' Clubs, sponsored by the Auxiliary, have encouraged a great number of young women to enter the nursing and allied health fields. Ask her if she has helped with this project lately?

During this coming year, and for years to come, it is my hope that we will continue to work closely with our medical societies and with the Florida Medical Association. We are here to help you. Just ask us!

Mrs. Wendell J. Newcomb, President

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## BOOKS RECEIVED

**The Chemical Prevention of Cardiac Necroses.** By Hans Selye, M.D., Ph.D., D.Sc. Pp. 235. Price, \$7.50. New York, The Ronald Press Company, 1958.

It is the purpose of this monograph to coordinate the many isolated observations on necrotizing cardiopathies in the light of newly acquired knowledge about the production and prevention of similar lesions in animals. It is hoped that such systemization of present knowledge will help to provide a better insight into the complex relationships between electrolytes, steroids, and stress, which the distinguished author believes to be fundamental for the understanding and prevention of many diseases.

Cardiac necrosis, the commonest cause of death in man, presents itself in many apparently unrelated forms, and experimental medicine provides an equally impressive list of necrotizing cardiopathies likewise apparently unrelated. One of the most striking results of the investigations here described was the demonstration that the production of necrotizing myocarditis by so many agents is uniformly influenced by corticoids and electrolytes. KCl and  $MgCl_2$  prevent, not only the typical ESCN (combined treatment with certain Electrolytes and Steroids produces a Cardiopathy characterized by Necroses, the "ESCN") induced by corticoids and sensitizing Na-salts, but also the suppurative myocarditis that is normally elicited by combined treatment with DHT plus  $NaH_2PO_4$ , the necrotizing myocarditis that develops in corticoid-conditioned rats during exposure to various stressors, and even those cardiac necroses that occur (presumably as a result of a direct proteolytic action) following intravenous treatment with a protease. These findings raise the hope that some of the spontaneous necrotizing cardiopathies of man may also be beneficially influenced by KCl or  $MgCl_2$ . It is of particular interest also that extracardiac effects of treatment with corticoids and electrolytes can likewise be prevented by KCl or  $MgCl_2$ . The facts already established suffice to show that the interactions between steroids and electrolytes have much more general implication in physiology and pathology than was hitherto suspected.

**Cardiac Arrest and Resuscitation.** By Hugh E. Stephenson, Jr. Pp. 378. Price, \$12.00. St. Louis, The C. V. Mosby Company, 1958.

Cardiac arrest has been estimated to be "the most catastrophic event that occurs in medicine," probably not alone because of the unexpectedness and suddenness with which it occurs but also because of its occurrence in almost any age group, under almost any type of condition, in patients who have had no previous cardiac disease. This book devoted in its entirety to the problems of sudden cardiorespiratory failure and subsequent resuscitative procedures is therefore timely. It brings together a concise summary of present day knowledge on cardiac arrest and resuscitation, with which nearly every physician, whether surgeon, anesthesiologist, cardiologist, pediatrician, or generalist, needs to be familiar. The co-operation of physicians the world over has made it possible for the author to establish The Cardiac Arrest Registry. Many of the conclusions presented in this book are based on a study of over 1,700 cases of cardiac arrest from this registry as well as from work done in the experimental laboratory over the past several years. There is also a most comprehensive bibliography. The reader will find that the many ramifications in the problems related to cardiac arrest extend into every realm of medicine. Knowledge of the problem has contributed greatly to a reduction in the morbidity and mortality associated with cardiac arrhythmias in recent years, and cardiac surgery has received its major impetus from effectiveness in the management of ventricular fibrillation and asystole. This authoritative volume on cardiac arrest should be of wide interest, for nearly all physicians at some time will be confronted with the challenging opportunity to resuscitate the acutely arrested heart.

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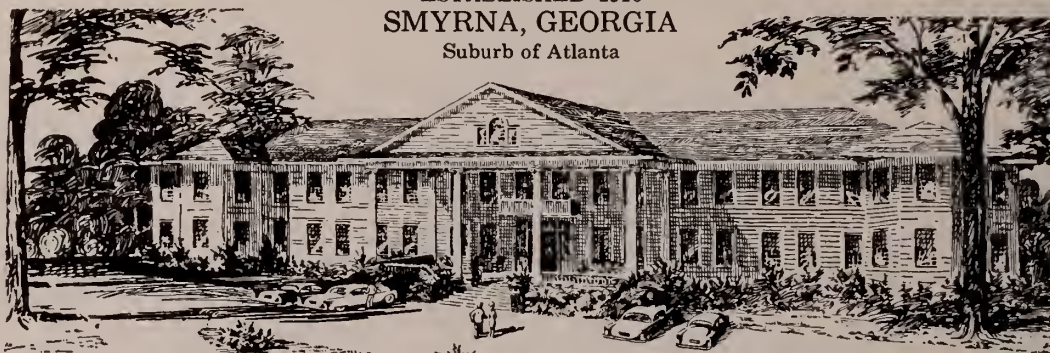
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# SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Ralph W. Jack, Miami.....	Samuel M. Day, Jacksonville.....	Jacksonville, April 8-12,
Florida Specialty Societies.....			
Academy of General Practice.....	Walter J. Glenn Jr., Ft. Lauderdale	A. MacKenzie Manson, Jacksonville	Miami Bch., Oct. 29-Nov
Allergy Society.....	James H. Putman, Miami.....	Ben A. Johnson Jr., Jacksonville	Jacksonville, April 8-12, '60
Anesthesiologists, Soc. of.....	George C. Austin, Miami.....	George H. Mix, Lakeland.....	Miami Beach, Oct. 4,
Chest Phys. Am. Coll., Fla. Chap.....			
Dermatology, Soc. of.....	Bruce M. Esplin, Miami.....	Jack H. Bowen, Jacksonville.....	Jacksonville, April 8-12,
Health Officers' Society.....	Chester L. Nayfield, Winter Haven	L. L. Parks, Jacksonville.....	
Industrial and Railway Surgeons.....	Lloyd J. Netto, W. Palm Beach.....	John H. Mitchell, Jacksonville.....	
Internal Medicine.....	Lawrence E. Geeslin, Jacksonville.....	Charles K. Donegan, St. Petersburg	Jacksonville, April 8-12,
Neurosurgical Society.....	W. Tracy Haverfield, Miami.....	Edward J. Sullivan Jr., Jacksonville.....	Jacksonville, April 8-12,
Ob. and Gynec. Society.....	Homer L. Pearson, Jr., Miami.....	Sam W. Denham, Jacksonville.....	W. Palm Beach, Dec. 5-6,
Ophthalm. & Otol., Soc. of.....	G. Dekle Taylor, Jacksonville.....	Joseph W. Taylor Jr., Tampa.....	Jacksonville, April 8-12,
Orthopedic Society.....	Elwin G. Neal, Miami Shores.....	Richard A. Worsham, Jacksonville.....	
Pathologists, Society of.....	James B. Leonard, Clearwater.....	John A. Shively, Bradenton.....	Chicago, Sept. 1959
Pediatric Society.....	B. A. Dobbins Jr., Ft. Lauderdale	Camillus S. L'Engle, Jacksonville.....	Jacksonville, Nov. 12-15,
Plastic & Reconstructive Surgery.....	Clifford C. Snyder, Miami.....	Bernard L.N. Morgan, Jacksonville.....	
Proctologic Society.....	Don C. Robertson, Orlando.....	Matthew A. Larkin, Miami.....	
Psychiatric Society.....			
Radiological Society.....	Russell D. D. Hoover, W. P. Bch.	John P. Ferrell, St. Petersburg.....	
Surgeons, Am. Coll., Fla. Chapter.....	George W. Morse, Pensacola.....	C. Frank Chunn, Tampa.....	
Surgeons, General.....	C. Burling Roesch, Jacksonville.....	Thad Moseley, Jacksonville.....	
Urological Society.....	Edwin W. Brown, W. Palm Beach	Wm. A. VanNortwick, Jacksonville.....	
Florida—			
Basic Science Exam. Board.....	P. A. Vestal, Winter Park.....	M. W. Emmel, Gainesville.....	Gainesville, Nov. 7, '59
Blood Banks, Association.....	Leo L. Foster, Tallahassee.....	Wilma Holt, Pensacola.....	Clearwater, May 13-15,
Blue Cross of Florida, Inc.....	Mr. C. DeWitt Miller, Orlando.....	Mr. H. A. Schroder, Jacksonville.....	Jacksonville, Dec. 2-4, '59
Blue Shield of Florida, Inc.....	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville.....	
Cancer Council.....	Joseph J. Zaveritnik, Miami.....	Lorenzo L. Parks, Jacksonville.....	Jacksonville, April 10, '60
Diabetes Association.....	J. J. Lowenthal, Jacksonville.....	Morris B. Seltzer, Daytona Bch.....	Miami Bch., Oct. 29-30,
Dental Society, State.....	A. D. Farver, Miami Beach.....	Richard Chace, Orlando.....	Miami Bch., May 15-18,
Heart Association.....	Sidney Davidson, Lake Worth.....	Mrs. E. D. Pearce, Miami.....	Miami, April 30, '60
Hospital Association.....	Ted L. Jacobsen, Clearwater.....	Joseph F. McAloon, Hollywood.....	Jacksonville, Dec. 2-4, '59
Medical Examining Board.....	George S. Palmer, Tallahassee.....	Homer L. Pearson Jr., Miami.....	
Nurses Association, State.....	Mrs. Idalyne Lawhon, Tampa.....	Mrs. Maurine Finney, Miami.....	Orlando, Oct. 13-16, '59
Pharmaceutical Assn., State.....	Rufus Thomas, New Smyrna Bch.....	Mr. R. Q. Richards, Fort Myers.....	Tampa, May 15-18, '60
Public Health Association.....	A. Y. Covington, Starke.....	N. J. Schneider, Jacksonville.....	Tampa, Sept. 24-26, '59
Rheumatism Society.....	Charles F. Tate Jr., Miami.....	Allen Y. DeLaney, Gainesville.....	
Tuberculosis & Health Assn.....	Ernest A. Lilley, Lakeland.....	Mrs. R. H. McIntosh, Port St. Joe.....	Ponte Vedra, Oct. 16-18,
Woman's Auxiliary.....	Mrs. W. J. Newcomb, Pensacola.....	Mrs. Max Suter, Jacksonville.....	Jacksonville, Apr. 8-12,
American Medical Association.....	Louis M. Orr, Orlando.....	F. J. L. Blasingame, Chicago.....	Miami Beach, June 13-17,
A.M.A. Clinical Session.....			Dallas, Texas, Dec. 1-4,
Southern Medical Association.....	Milford O. Rouse, Dallas, Texas.....	V. O. Foster, Birmingham.....	Atlanta, Ga., Nov. 16-19,
Alabama Medical Association.....	William R. Carter, Repton, Ala.....	Douglas L. Cannon, Montgomery.....	Mobile, Ala., April 21-23,
Georgia, Medical Assn. of.....	Luther H. Wolff, Columbus, Ga.....	Chris J. McLoughlin, Atlanta.....	Columbus, Ga., May 1-4,
Fla. Chap. Arthritis & Rheuma- tism Foundation.....	John P. Mozur, Miami.....	J. Charles McKee Jr., Miami.....	
S. E. Hospital Conference.....	Oscar S. Hilliard, Ft. Oglethorpe, Ga.....	Glenn Hogan, Atlanta.....	Miami Beach, May 3-7,
S. E. Am. Urological Assn.....	Lawrence Thackston, Orburg, S.C.....	S. L. Campbell, Orlando.....	Jacks'ville, March 13-16,
Southeastern Allergy Assn.....	C. P. Wofford, Johnson City, Tenn.....	Kath. B. MacInnis, Columbia, S.C.....	
Southeastern Surgical Congress.....	M. M. Copeland, Washington, D.C.....	B. T. Beasley, Atlanta.....	N. Orleans, March 21-24,
Gulf Coast Clinical Society.....	William J. Atkinson, Mobile, Ala.....	Dan Sullivan, Mobile, Ala.....	Mobile, Ala., Oct. '59



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School of Medicine	1961	Miami
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Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues	34
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues	67
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Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed	10
* Baker				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues	959
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues	360
* Clay				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues	117
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed	6
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Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues	12
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Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed	36
* Sumter				
Lee-Charlotte-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon	43
Leon-Gadsden-Liberty-				
Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon	80
Madison	Thomas G. Boulard Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues	32
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues	35
* Levy				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs	17
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs	9
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed	244
* Osceola				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon	177
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Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri	6
* Dixie				
Volusia	Alphonsus M. McCarthy, Daytona Beh.	John J. Cheleden, Daytona Beach	2nd Tues	102
* Flagler				
Walton-Okaloosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues	34
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

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(1) Rubin, A., and Babbott, D.: J.A.M.A. 168:498, (Oct. 4) 1958. (2) Kinsey, A. C.; Pomeroy, W. B., and Martin, C. E.: Sexual Behavior in the Human Male, Philadelphia, W. B. Saunders Company, 1948.

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*12*

# The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLVI

AUGUST, 1959

No. 2



M J D

OFFICIAL PUBLICATION OF THE  
FLORIDA MEDICAL ASSOCIATION



**in epileps**

## **PREREQUISITE FOR EMOTIONAL ADJUSTMENT: THERAPY**

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**bibliography:** (1) Carter, S. M.: *M. Clin. North America*: 315 (March) 1953. (2) Chao, D. H.: *Ibid.*, p. 465. (3) Gilman, L. S., & Gilman, A.: *The Pharmacological Basis of Therapeutics*, ed. 2, New York, MacMillan Company, p. 187. (4) Davidson, D. T., Jr., in Conn, H. E.: *Current Therapy* 1958, Philadelphia, W. B. Saunders Company, 1958, p. 568. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) French, E. G.; Rey-Bellet, J., & Le W. G.: *New England J. Med.* 258:892 (May 1) 1958.





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VOLUME XLVI, No. 2

• August, 1959

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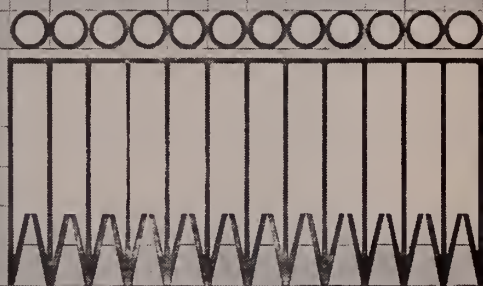
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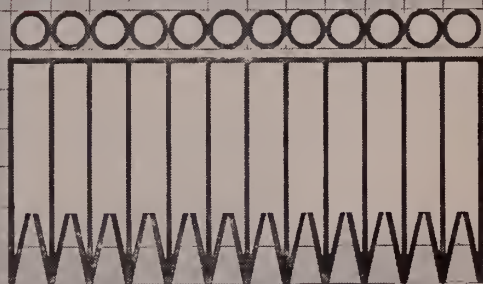
1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

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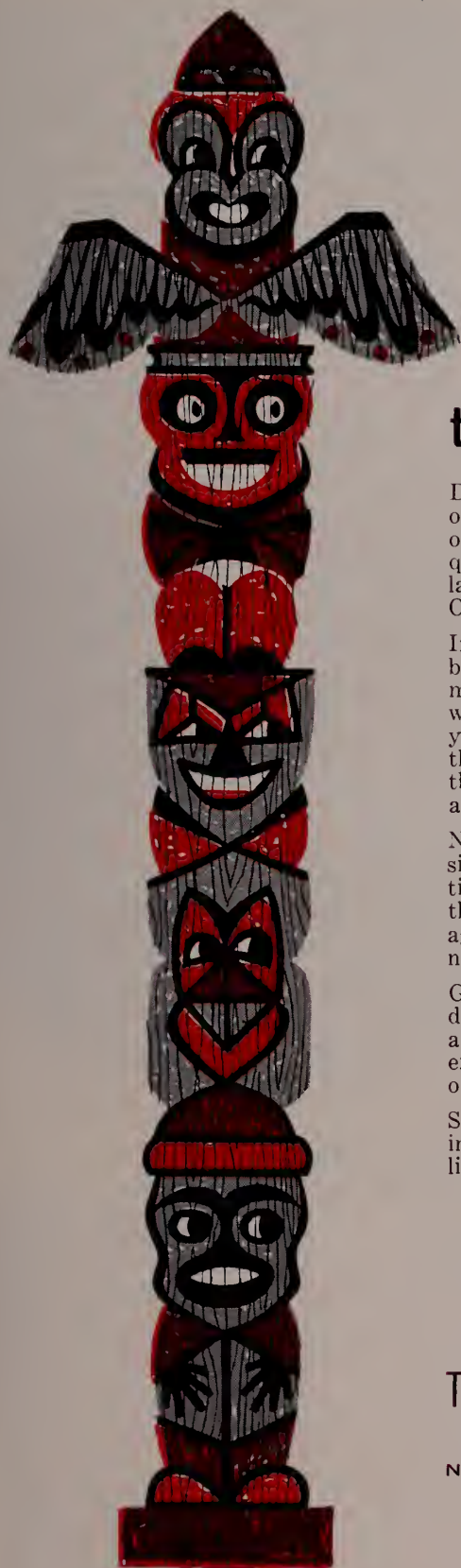
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Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

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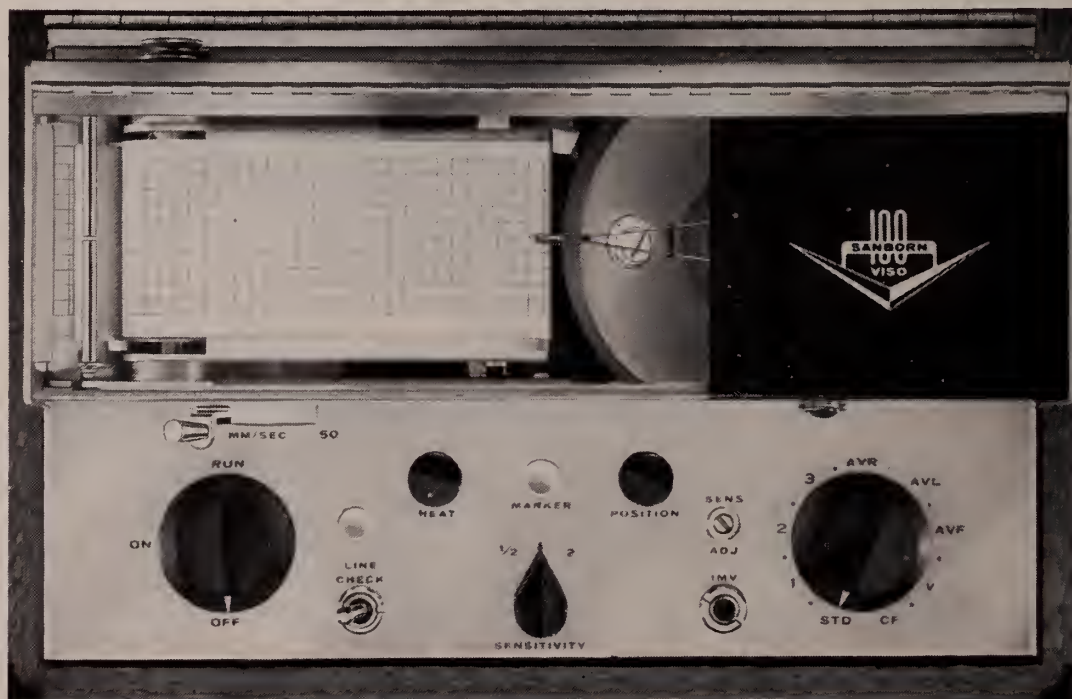




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dysmenorrhea

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## case profile no. 2758\*

A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

*\*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

for low back pain





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**Trancopal®**

for dysmenorrhea  
and premenstrual tension



## case profile no. 3347\*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

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## **potent muscle relaxant** **effective tranquilizer**

- In musculoskeletal disorders, effective in 91% of patients.<sup>1</sup>
- In anxiety and tension states, effective in 88% of patients.<sup>1</sup>
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

### **Indications:**

#### **Musculoskeletal:**

Low back pain (lumbago, etc.)  
Neck pain (torticollis, etc.)  
Bursitis  
Rheumatoid arthritis  
Osteoarthritis  
Disc syndrome  
Fibrositis  
Ankle sprain, tennis elbow, etc.  
Myositis  
Postoperative muscle spasm

#### **Psychogenic:**

Anxiety and tension states  
Dysmenorrhea  
Premenstrual tension  
Asthma  
Angina pectoris  
Alcoholism



Trancopal Caplet  
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**Dosage:** Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

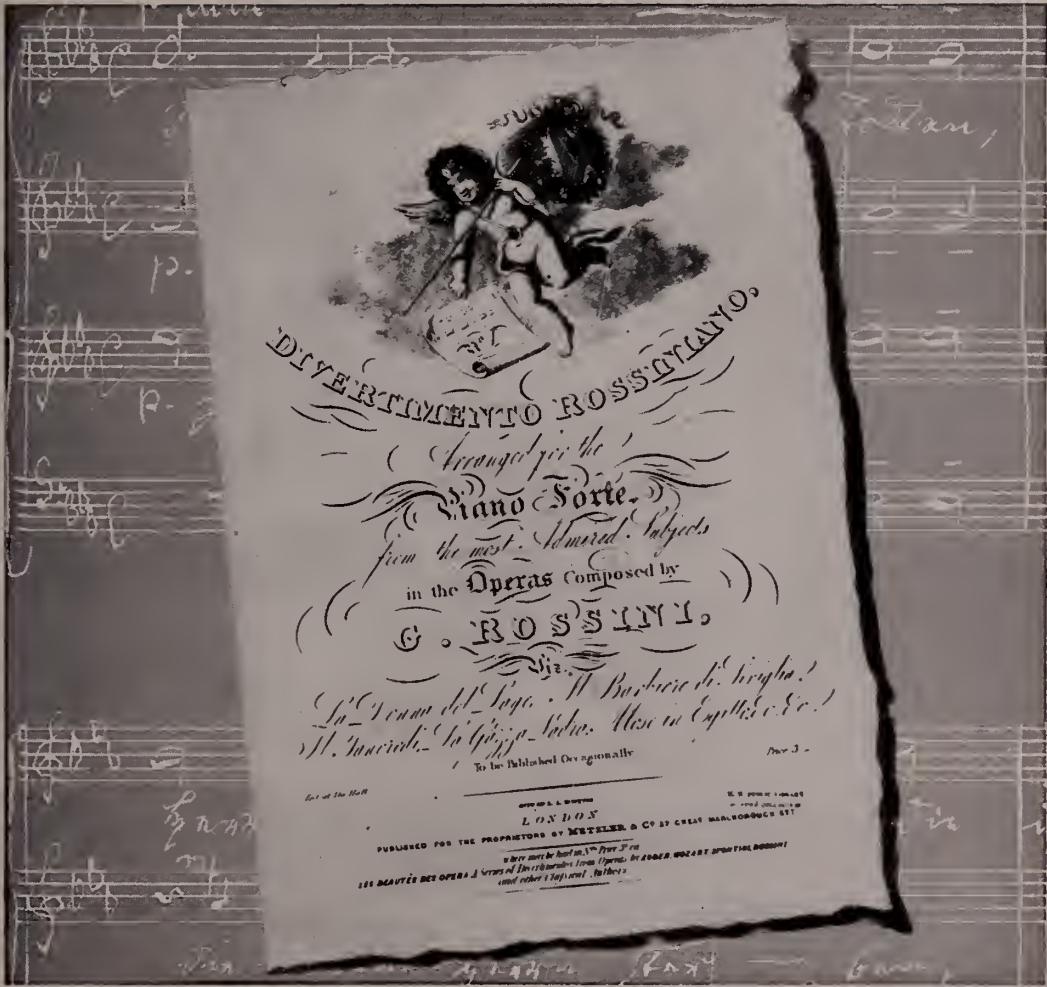
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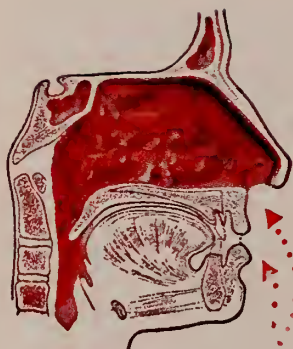
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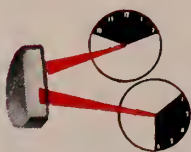
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*References:* 1. Sheldon, J. M.: *Postgrad. Med.* 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: *Annals Allergy* p. 350 (May-June) 1950. 3. Kline, B. S.: *J. Allergy* 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: *Pharmacol. Basis Ther.*, Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: *E.E.N.T. Monthly* 37:460 (July) 1958. 6. Lhotka, F. M.: *Illinois M.J.* 112:259 (Dec.) 1957. 7. Farmer, D. F.: *Clin. Med.* 5:1183 (Sept.) 1958.

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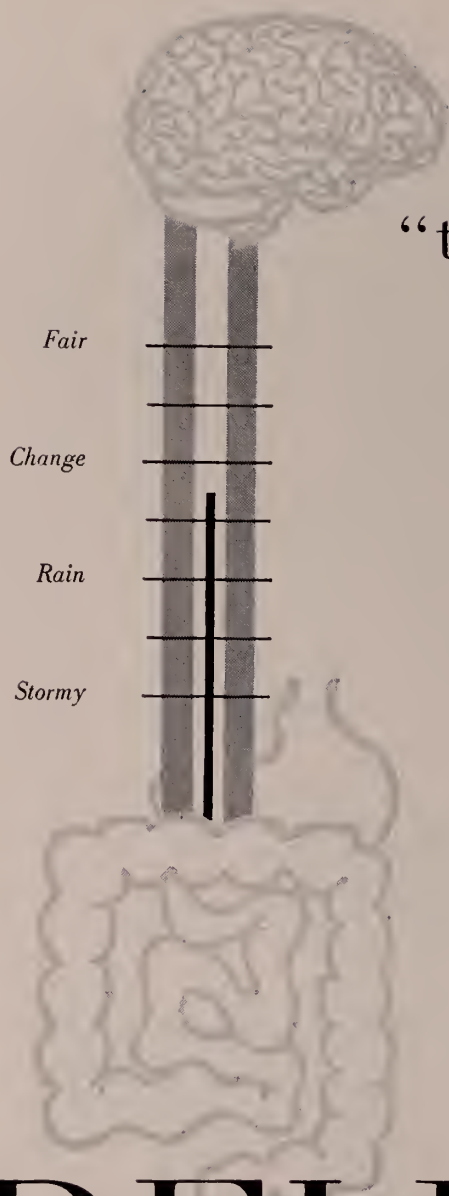
**Dosage:** One tablet before each meal.

**Supplied:** In bottles of 100 blue-and-white scored tablets. Prescription only.

**References:** 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.



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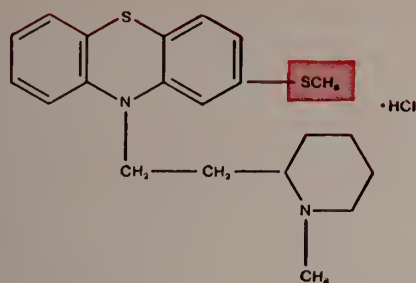
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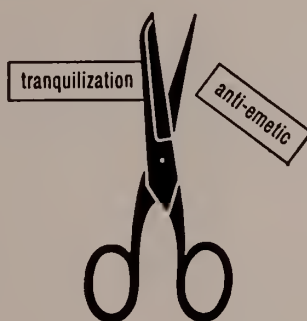
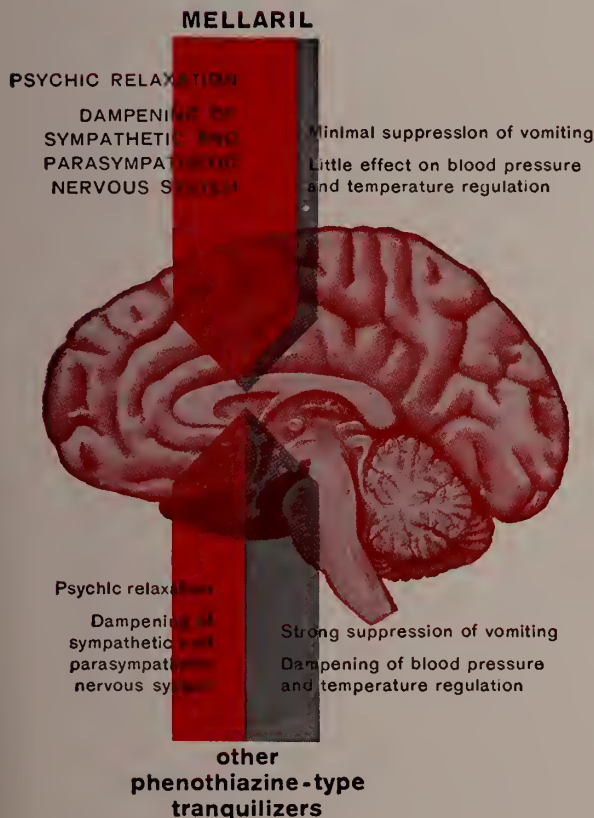
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## A.M.A. Reorganization Its Real Significance

F. J. L. BLASINGAME, M.D.  
CHICAGO

My sincere thanks to you, President Annis, for the invitation to address this Eighty-Fifth Annual Meeting of the Florida Medical Association. On behalf of the American Medical Association, the Board of Trustees, and the headquarters officers and staff, I bring you greetings.

Being here today is a particular honor. It gives me the opportunity to salute the Florida Medical Association for several important contributions to the American Medical Association. First, you have supplied the Association with its next President, Dr. Louis M. Orr of Orlando. For many years Vice Speaker of the House of Delegates, Doctor Orr has contributed his leadership and ideas to the better functioning of the House and the Association. During his term as President-Elect, Doctor Orr already has done yeoman service; and we are looking forward to a great 1959-1960 with Doctor Orr as our Association's President.

I also want to congratulate the Florida Medical Association for allowing the A.M.A. to employ the talents and time of Doctors Chrisman, Holland, and Pearson in the House of Delegates, on the Council on Medical Service, on the Judicial Council, and on various committees through the years. Other members of your society have worked diligently. May I also congratulate you on an effective staff at the state level?

Finally, let me say that the American Medical Association is pleased that in 1960 it will be holding its annual meeting here in Florida—the first time since 1941 that this huge session has been outside the four cities of New York, Chicago, Atlantic City, and San Francisco.

Executive Vice President, American Medical Association.  
Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 4, 1959.



Dr. Blasingame

### Significance of A.M.A. Reorganization

This morning I should like to spend the remainder of my time talking with you about the real significance of the A.M.A. reorganization. Let me begin, however, by giving you a personal reaction on American Medicine's accomplishments and position—past and present. It is this:

Never has *so much* been done for *so many*—so well!

The “so much” is evidenced by the scores of dramatic advances that have been made in the scientific aspects of medicine and in the socio-economics of medical care.

The “for so many” means that all Americans, in fact, people of the entire world have benefited by the miracle break-throughs in medical science and by the steady advancements in the prevention, diagnosis, and treatment of illness and in rehabilitation.

The “so well” is a deserving tribute to well trained personnel in medicine—its physicians, nurses, and all the dedicated men and women in allied fields; it is a tribute to the modern facilities

developed to care for patients, the research centers and the voluntary health insurance which covers so many persons today.

Never have Medicine and its allies been so well equipped to give the best possible medical care. Never have we done a better job for the people we serve. Naturally, we have not attained our ultimate goal. We never shall, but Medicine with its allies will continue to strive for the best possible care for all Americans.

I would be less than honest if I failed to add that despite all our progress, and the promise of greater advancement, American Medicine remains in jeopardy and is waging a continual struggle for its own freedom and for the freedom of those whom we serve. Because Medicine is so significant in modern society and because Americans have an intense interest, and rightly so, in all things applicable to their own physical well-being, certain leaders would like to use medicine to further their own end. Some would tax the populace, control the purse, and have medical service become a function of government. Other nations have done likewise, and the consequences are well known. Without exception, the quality of medical care has deteriorated; and the cost has gone up. Talented young men seek other professions. Medical research and practice have become less productive. The personal relationship between patient and physician has been damaged.

Perhaps the growing desire of some legislators to push their way into the medical picture with their compulsory schemes is a result of our changing social environment and philosophy. Today, many citizens tend to demand their rights, with less emphasis placed on individual responsibilities. Personal security is worshiped; and, if the government will guarantee that security, so much the better. An insidious encroachment, a constant sniping away at personal freedoms, is becoming alarmingly evident and contrary to the fundamental concepts of our American way of life. Often an apathetic public has allowed certain freedoms to be lessened or lost completely.

#### Outlook for American Medicine

No wonder then that American Medicine is being regarded by many as a public utility. What is the outlook for American Medicine under the circumstances?

I am confident it can be good.

I do not subscribe to the doctrine of inevitable socialization, and to do so is psychologically bad and tactically stupid.

I have faith that a sufficient number of thoughtful men and women realize the value of freedom and, therefore, will defend it adequately.

I believe that the institution of private practice can be preserved and made to serve even more fully the needs of modern society.

I have confidence that the majority of Americans believe in voluntary action in the matter of personal health care and that this majority wants no compulsory system in this area or in any other area of their lives.

Perhaps, Americans are not showing enough public concern for the recent vivid and horrible examples of the compulsory system in action around the world. Even if we did not react openly over the blood baths in Hungary and Tibet, the suppression of religion behind the Iron Curtain, the curtailment of a free press, and the enslavement of whole populations, I still believe that individual American citizens are outraged over these events and have resolved to themselves that these things shall not happen here.

Within our own profession, and within the health team, it is essential that we maintain a determination to keep our system of private practice and physician and patient freedoms. I sincerely hope that as *individuals* we are determined to prevent third party control of American Medicine and medical care.

I also hope that every medical group—national, state, and local—and every allied health organization will decide quickly, if they have not done so, to get behind the idea of voluntarism in all matters concerning the health care of the American people. If American Medicine could have an accord on the single precept of voluntarism, all of its component state and local medical societies, all of its specialty groups at every level, all the allied health groups—the hospitals, nurses, pharmacies and insurance industry, and the scores of others—it would have a mighty force in action *for* the voluntary way in health care, *against* the compulsory system and for even better health and well-being of the people whom we are dedicated to serve.

#### A Stimulus to Unity

The American Medical Association has realized that there has been a great deal of splintering within the medical profession and within the allied medical groups. Get back far enough from the scene and you probably would see a great patchwork quilt of medical associations and health organizations. Obviously we need to draw closer

together; to act and function as an even more effective health team and as a force for the voluntary system.

To make our own operation—the operation of the American Medical Association—more effective in professional and public matters, the Association has been reorganized. In so doing we hope to be the *stimulus* that can help to bring unity to the whole patchwork quilt that now exists in the medical and health care fields. We seek cohesion within the medical profession; we seek greater liaison and cooperation with all groups in the health picture. We seek smoother and greater communications within this whole health team.

I believe that the American Medical Association has the stature, the experience and the resources to lead and guide in this task of getting the greatest mileage out of our program of scientific work, and our socioeconomic research as well as our extensive effort for the public—from meeting the health needs of the aged to fighting medical quackery and to maintaining the high educational and ethical standards of physicians.

Reorganization of your A.M.A. has not been a hit-or-miss proposition. It has some short range goals in mind, of course; but essentially it has been aimed at the long range purposes of a united, alert, and dynamic organization that will serve all the profession and all the people of this country. I hope that out of this reorganization and the efforts now being undertaken, the medical profession and the public will become more aware of the sound, solid, enlightened job we are doing. I am convinced, as I know you must be, that the interests of the public and the profession are closely tied together in scores of health matters—whether they involve medical care, research, economics, or education.

American Medicine is important to our society. Physicians, their work and the work of their associations, are a part *of* society, and certainly we must never be apart *from* our society.

We do not intend to attain merely a better image of the A.M.A. in the eyes of the public. By our work, however, in behalf of the public and the betterment of the profession, we certainly hope that the American people will quickly realize even more completely that your Association is laboring in the public interest.

My personal wish is that we can develop all our idea-power and staff “horsepower” within the profession. This means obtaining the participation of more and more physicians at the local and state levels. Here, again, I am firmly convinced

that the fires of enthusiasm must be kindled at the grass roots. At first that may sound somewhat trite to you, but believe me, it is not. No organization can lead with strength if its members are not contributing their creative thought and following up with positive action.

#### **Staff Reorganization**

To aid all 175,000 members of the American Medical Association, we at headquarters have been building a staff that has depth and proven ability in its respective fields. To keep the operation as simple and direct as possible the A.M.A. headquarters staff has been organized into eight divisions. Here briefly are those divisions:

- 1 — Business
- 2 — Law
- 3 — Field Service
- 4 — Communications
- 5 — Socioeconomic
- 6 — Scientific Activities
- 7 — Scientific Publications
- 8 — Washington Office

#### **American Medicine a Pivotal Group**

Medicine, I believe, never was stronger in its ability to serve and to meet human needs. Nevertheless, the American Medical Association intends to improve upon that ability and to strive for perfection.

Medicine never had more formidable adversaries, but Medicine never had stronger friends. I hope that the A.M.A. can win over some of the adversaries and cooperate further with our friends.

Medicine is in danger of being led, but it never had greater opportunities for leadership. Your A.M.A. intends to seize those opportunities and lead—now and in the future. It is not going to be led.

Yes, I believe that our sincere efforts will prove that American Medicine is a pivotal group around which agriculture, insurance, industry, labor and others may rally in the preservation of many American freedoms, private competition, dignity of person and respect of property, and many other significant values that make life in our country particularly worth while.

Our profession has had a great past, has a remarkable present, and has a challenging and engaging future. Medicine is destined to be a vital part of the texture of the future society. We intend to make the most of it for the American public—the patients whom all of us serve.

535 North Dearborn Street.



# Comparative Oral Glucose and Fructose Tolerance Tests in Normal Subjects And in Diabetic Patients

CARLOS P. LAMAR, M.D.

MIAMI

It is generally held that all or most of the fructose taken by mouth is converted to glucose in the body.<sup>1</sup> If this view is correct, almost identical postabsorptive curves of blood glucose levels should be obtained after the oral intake of either glucose or fructose in equal amounts by the same person. In the case of a diabetic patient suffering from a hypoglycemic reaction, the oral intake of fructose should result in the same degree of relief as that obtained from the ingestion of sucrose or of glucose.

My observations during the past five years on diabetic patients receiving insulin have shown that the oral intake of fructose consistently results in a failure to relieve the signs and symptoms of hypoglycemic reactions, even with amounts of fructose reaching sometimes more than 100 Gm., which is more than 10 times the amount of glucose usually required by these patients to correct their reactions.

A series of paired glucose and fructose oral tolerance tests was performed in about 100 diabetic and nondiabetic volunteers, each test a few days apart in the same person. The postabsorptive curves of blood glucose were found to be consistently higher after the ingestion of glucose than the corresponding curves after the ingestion of fructose. The incidence of postabsorptive glycosuria after fructose was negligible except in the most severe cases of diabetes, and even in them postabsorptive glycosuria was significantly less severe than after the ingestion of an equal amount of glucose.

The paired glucose and fructose tolerance tests performed in 26 subjects are presented here. They were chosen because their initial or fasting levels of blood sugar were comparable on the basis of tests performed. All of these subjects had been

on a normocaloric diet, divided into six regular daily meals, breakfast, mid-morning snack, lunch, mid-afternoon snack, dinner and bedtime snack,<sup>2</sup> for at least five days prior to the first test, and throughout the second test. The total daily intake of fat was restricted to less than 60 Gm., while the intake of carbohydrate, including liberal amounts of sucrose, was more than 300 Gm. Insulin, when required, was taken usually in the form of one morning dose of Lente U-80. The doses of insulin were regulated in an attempt to prevent heavy glycosuria and/or total aglycosuria with its concomitant insulin reactions.

The patients were ambulatory. The oral tolerance tests were performed after a fast of nine to 11 hours, and the morning injection of insulin was postponed until after the test was completed. Each patient was scheduled for the two separate tests on mornings at least five days apart. Sometimes the tests were first performed with glucose, and in other cases first with fructose. To avoid confusion, in the accompanying graphs the first column (G) represents the oral glucose tolerance test and the second column (F) the oral fructose tolerance test. The dates on which the tests were performed are recorded as well as the patient's initials, sex and age, and the number of the record.

All the subjects included in this series ingested 100 Gm. of glucose in one test, and 100 Gm. of fructose in the other. The sugar was dissolved to a total volume of 500 cc. with cold water flavored with lemon or lime juice. The tolerance for this solution has generally been excellent. Many patients enjoy the flavor, but some diabetic patients of long standing, unaccustomed for years to sweets, do not. It was soon learned that instead of the limeade or lemonade, they prefer to swallow the sugar in a smaller volume of up to 250 cc. and to "wash it down" with 250 cc. of unsweetened hot coffee. Before this method was adopted, there were occasional instances of nausea, vomiting, and even diarrhea following the intake

From the Department of Internal Medicine, Jackson Memorial Hospital, Miami, and Doctors Hospital, Coral Gables. Appreciation is expressed to the Medical Research Department of Mead Johnson & Company, which supplied the fructose used in most of these studies, and to the Sugar Research Foundation, Inc. for grants in partial support of this work.

of either fructose or glucose, but apparently more frequently after the intake of the fructose solution, which is several times sweeter than glucose.

After specimens of venous blood and of urine in the fasting state had been collected, the patients drank the test solutions during a period of three to five minutes and usually remained resting quietly in bed for the duration of the test. Specimens were again obtained 30 minutes and one, two, and three hours later.

Every specimen of urine was examined immediately for the presence of sugar and acetone. The latter was found only in two fasting specimens in this series and has therefore not been recorded on the graphs. The presence and intensity of glycosuria were determined by the "Clinitest" method and recorded at the bottom of each chart grossly as "zero" to "four plus." Determinations of the "true blood glucose" concentrations were made by the Somogyi-Nelson method,<sup>3,4</sup> blood fructose determinations by the method of Weichselbaum, Margraf and Elman<sup>5</sup> and serum inorganic phosphorus levels by the method of Fiske and Subbarow<sup>6</sup> as modified by Roe and Whitmore.<sup>7</sup> Only in the case of hepatic diabetes (fig. 6) are the curves of phosphatemia included in this report. All figures for blood or serum represent milligrams per hundred cubic centimeters.

The glucose used in this work was "Dextrose, C.P., Reagent." The fructose used in the first few tests was of the same quality. "D-Levulose, C.P., Reagent," but its prohibitive costs limited the work until the Medical Research Department of Mead Johnson & Company provided a generous supply of "Syrup Fructose, 75% w.w." Although this is in liquid form instead of the crystalline form, such fructose is reported to be pure and its tests was of the same quality, "D-Levulose, C.P., To insure the intake of 100 Gm. of the sugar, 133 Gm. of the syrup was used to make up the required volume of 500 cc.

## Results

Figure 1 shows the results obtained in three controls. Number 1 was a 38 year old man who had been in remission for over a year from a previous state of mild clinical diabetes. Number 2 was a 15 year old girl with mild chronic asthma and recurrent episodes of mild thyroiditis. Number 3 was a 46 year old woman with a mild degree of adrenal dysfunction related to chronic emotional tension. Though the three subjects showed post-absorptive curves of blood glucose which were

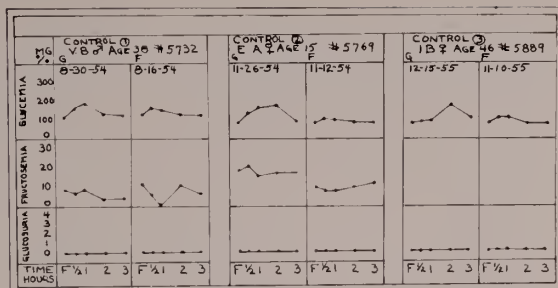


Fig. 1. — Three nondiabetic controls showing variants of normal postabsorptive blood glucose levels following ingestion of 100 Gm. of glucose and much lesser elevations following the intake of 100 Gm. of fructose.

slightly different from each other following the ingestion of glucose, the blood glucose levels following the ingestion of fructose were similar in all three, with only minimal elevation and only during the first hour.

Figure 2 shows the curves obtained in three women, aged 66, 58, and 25 years, and in three men, aged 60, 55 and 57 years respectively. All but the youngest one (case 3), who was an ex-"juvenile diabetic" then well adjusted, had severe diabetes with long-standing vascular degenerative complications. In cases 1, 4 and 6 fasting blood glucose levels at the beginning of both tests were almost identical. The difference in the response to the two sugars is obvious, with significantly lower increases following the intake of fructose as compared with those after the ingestion of glucose. In case 2 there was a slightly higher fasting glycemia on the day of the glucose tolerance test, but the end result in three hours still showed a significantly lower degree of hyperglycemia following the intake of fructose than the original differential of fasting levels would warrant, even if in this instance, as in a few others, blood glucose levels became high after fructose intake. The patients in cases 3 and 5, on the other hand, had a higher fasting level of glycemia on the days of the fructose test and yet, both showed smaller increases on these days than on the days of the glucose tests. Postabsorptive glycosurias were significantly lower after the ingestion of fructose than after glucose intake in at least four of the six cases in this group.

Figure 3 depicts the results in two women aged 31 and 55 years, and two men aged 38 and 55 years, all four with severe hypertensive neuropathy, and three of them (cases 1, 2 and 4) almost totally blind from diabetic retinitis proliferans. In all four patients, but particularly in the men, there were striking differences in the post-

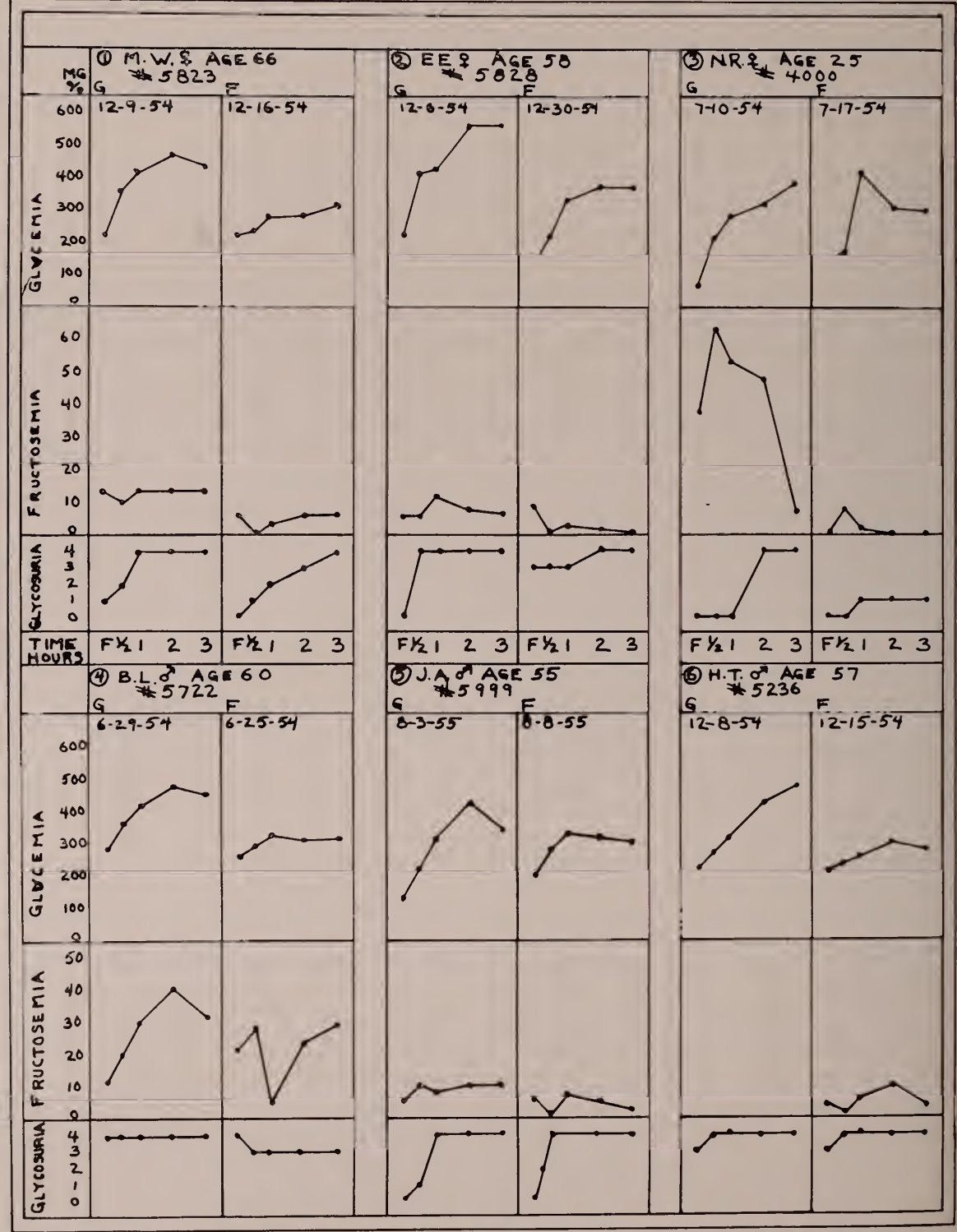


Fig. 2. — Six patients with severe diabetes showing typical glucose tolerance curves. Following the intake of 100 Gm. of fructose the hyperglycemias are significantly less severe as well as the glucosurias.

absorptive curves of glycemia and glycosuria. It is remarkable that the curves of the glucose tolerance tests were so similar in all four cases, and also that the postabsorptive glycemias in the respective fructose tolerance tests were so much

lower in the cases of the two men, almost like those of nondiabetic patients, even considering the fact that there was then a somewhat better metabolic state as shown by the lower fasting glycemic levels. Though all four patients had



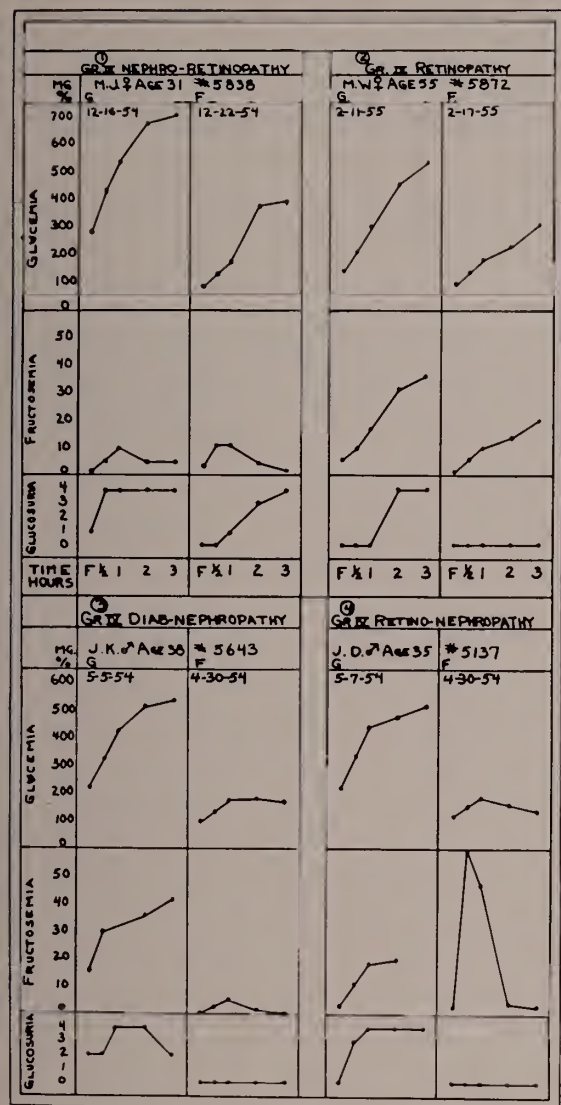


Fig. 3.—Four patients with severe diabetic degenerative complications, typical diabetic glucose tolerance curves and heavy glucosurias. In the oral fructose tolerance test only one had glucosuria, and in two the glycemics were only slightly raised.

substantial glucosuria in the glucose test, only the patient in case 1 had any on the fructose test and it was less than after glucose intake. Although it is not intended in this report to discuss the fructose blood levels in detail, it appears to be of some interest that the postabsorptive curves of blood fructose after the intake of glucose showed in many instances a striking parallelism with the actual glucose elevations. This may suggest that while some of the ingested fructose may reach the blood stream as glucose, perhaps also some of the glucose is converted to fructose (fig. 2, case 4; fig. 3, cases 2, 3 and 4; fig. 4, case 1; fig. 5, cases 4, 5, 6 and 8).

Figure 4 shows findings in two cases of extremely labile diabetes of the so-called "malignant" type in a man aged 25 and a woman aged 67 years. In both patients, unpredictably severe hypoglycemic reactions frequently alternated with bouts of acidosis, and both were markedly insulin-sensitive. In each of these two cases, on the day of the fructose tolerance test the metabolic status was apparently worse than on the day of the glucose test, as shown by significantly higher fasting blood glucose. Yet, in both cases the typically severe postabsorptive hyperglycemia following the intake of glucose contrasted sharply with hardly any at all after the ingestion of fructose, and with significantly lower glycosuria in the fructose tolerance test.

Figure 5 shows the tests in 10 diabetic subjects, four men, aged 39 to 66 years, and six women, aged 44 to 71 years, all of them with from moderate to severe diabetes. All 10 pairs of graphs have in common that the fasting blood glucose, and presumably the respective metabolic status, were almost identical for both tests in every case. In all 10 cases the blood glucose was significantly lower, and in at least two cases (8 and 9), it did not rise at all after the intake of fructose, while typical diabetic curves followed the ingestion of glucose in every instance. Glycosuria in the post-absorptive period was present and was fairly intense in all cases after the ingestion of glucose.

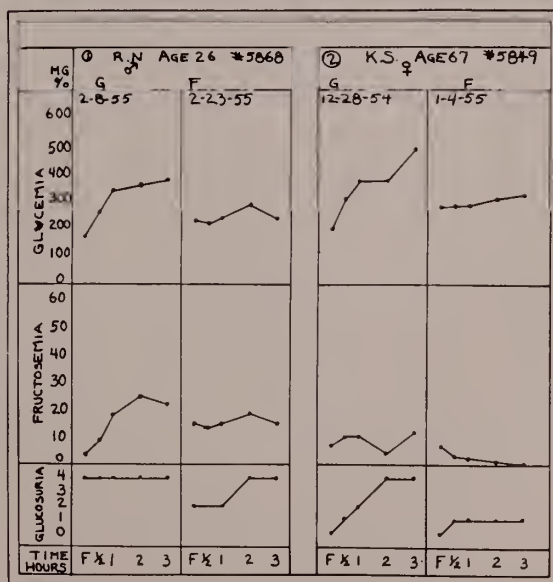


Fig. 4.—Two subjects with extremely severe labile diabetes. Despite higher fasting levels on the days of the oral fructose tolerance tests, postabsorptive glycemic levels did not increase significantly and the glucosurias were reduced.

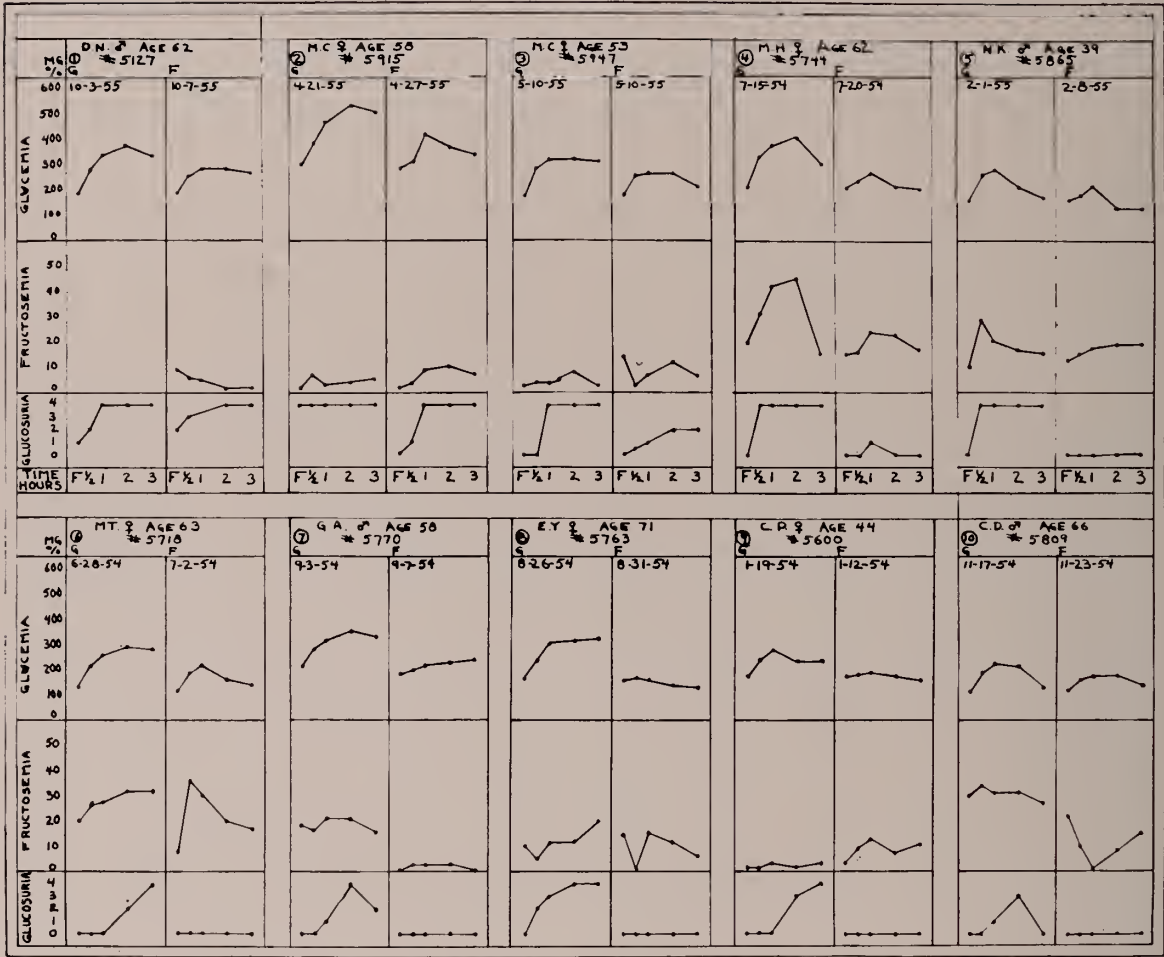


Fig. 5.—Ten cases of moderate to severe diabetes in all of which the starting or fasting levels of blood glucose were almost identical for both tests in each subject. Postabsorptive glycemias following fructose intake were significantly lower in all 10. In cases 8 and 9 there were no significant elevations. In the first three cases there was less glucosuria, in the fourth only a trace and in the other six none at all after fructose ingestion.

It was totally absent in six and markedly lower in the other four after the fructose intake.

Figure 6 shows one case of liver disease in a 58 year old man with intermittent hyperglycemia and glycosuria. In the glucose tolerance test there were hyperglycemia and glycosuria. In the fructose tolerance test, the blood glucose oscillated slightly above and below the fasting level without significant elevation and there was no glycosuria. Serum inorganic phosphorus levels were inconclusive, but corresponded to other evidence in this subject indicating hepatic disease, with possibly better phosphorylation of fructose than of glucose.

Discussion and Comments

The evidence presented in these tables seems to indicate that fructose, when ingested by mouth in man, is not all converted into glucose by the intestinal mucosa.

Apparently, fructose may also reach the blood stream as such, and then enter the metabolic pathways through phosphorylation to fructose-1-PO<sub>4</sub>. This reaction, catalyzed by the enzyme fructokinase, apparently does not require insulin.

Part of the fructose ingested, as well as part of the glucose, is probably always converted to glycogen. From studies in the rat by Stetten and Boxer,<sup>8</sup> it appears, however, that the total amount of glycogen stored in a normally fed animal in 24 hours is equivalent to only about 3 per cent of the total carbohydrate metabolized. Hence, as Loeb<sup>9</sup> concluded, "stored liver glycogen, although of vital importance as an emergency stabilizing factor for the blood sugar level, appears to be almost insignificant as a source of glucose for the metabolic requirements of the normal animal."

It seems, then, that it may be possible for the diabetic patient to absorb and to metabolize enough fructose taken by mouth to cover a significant proportion of his daily metabolic requirements without insulin, and to convert only a relatively small portion of the fructose into glycogen, to be released later as glucose through the hexokinase reaction requiring insulin.

The postabsorptive curves of blood fructose after intake of glucose suggest in a significant number of cases presented here that the converse may also occur, namely, that some portion of the ingested glucose may be converted to fructose. At any rate, it is perhaps important that both hexoses must pass through the state of fructose-6-PO<sub>4</sub>, before reaching the tricarboxylic cycle of Krebs.<sup>10</sup>

The frequent absence of a substantial rise of blood glucose after the oral intake of fructose not only may explain the failure of fructose to relieve insulin hypoglycemic reactions, but seems also to be in keeping with the reported absence of fructokinase in brain tissue. It may, in addition, explain why only glucose as such, or derived from sucrose, relieves the symptoms of hypoglycemia. Brain cells require a constant supply of oxygen and calories, which is derived from glucose-glycolysis catalyzed by hexokinase that is abundantly present in brain tissue. Apparently, fructose cannot replace glucose in this process because of the lack of fructokinase in brain tissue.

Competent reviewers of this paper have offered certain criticisms. As I do not believe that they constitute a valid negation of the facts herein presented, they are included here with my answers:

“The first sentence in the paper is no doubt true, but leaves out of consideration the rate at which the conversion takes place. Perhaps more important in this connection is the speed of absorption. Work on laboratory animals by both the Corys and Verzar has shown that fructose is absorbed only 43 to 44 per cent as fast as glucose and that the phosphorylation or whatever the living tissue superimposes on diffusion plays a relatively minor role as compared to glucose. Perhaps the fructose is not absorbed at a sufficiently rapid rate to be effective in insulin hypoglycemia.”

“The question of possible variations from normal in the diabetic with respect to the fructose → glucose conversion and the rate of fructose absorption is also pertinent. Judging by what happens in the kidney, the passage of glucose

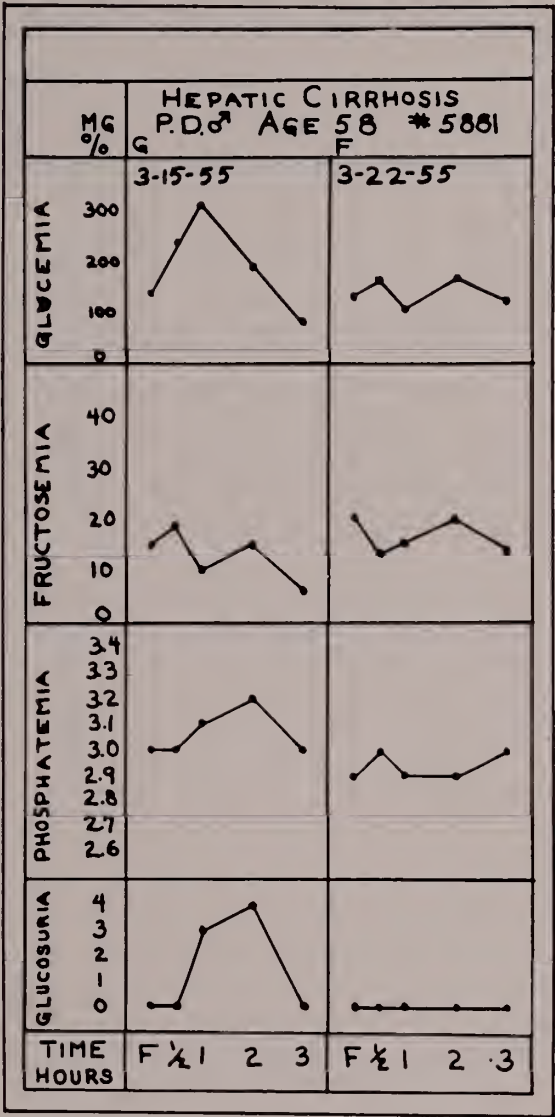


Fig. 6. — A patient with confirmed cirrhosis of the liver and disturbed glucose metabolism to the point of intermittent hyperglycemias and glucosurias. Following fructose intake the blood glucose levels were not significantly disturbed and no glucosuria appeared.

from the lumen of the intestine to the blood stream might be accelerated in the diabetic. This, however, says nothing about the diffusion process by which fructose is apparently mostly absorbed.”

“It appears to be accepted that fructose is better utilized by the diabetic than glucose and that utilization does not require insulin. If one accepts the current argument that perhaps the main function of insulin is to aid in a ‘transfer’ mechanism, fructose is not affected. (Fed. Proc. 11, 56, 1952). How then does the fructose enter the cell where fructokinase presumably functions? By diffusion? If so, the rate of utilization would never be as great as that of glucose. Is it not to



be expected that there would be differences in the tolerance curves shown by glucose and fructose?"

Even if fructose were absorbed *in man* only 43 to 44 per cent as fast as glucose, that would represent but a few minutes delay in the correction of insulin-induced hypoglycemia. Repeatedly, I have given amounts of up to 120 Gm. of pure fructose in solution to normal subjects and to diabetic patients, all while undergoing insulin-induced hypoglycemia. No relief of the reaction nor elevation of the total blood sugar was produced for as long as 90 minutes to three hours. On the other hand, the ingestion of either 10 Gm. of pure glucose or of 20 Gm. of sucrose in solution invariably resulted in the relief of hypoglycemic signs and symptoms, as well as in elevation of total blood sugar after only 10 to 20 minutes. A report is in preparation.

The graphs of several of the cases in this paper seem to indicate that the rate of absorption and utilization of fructose may be probably as high, or even higher in some instances, than that of glucose.

The objection that the "diffusion" of fructose would be slower than the "transfer" of glucose is purely theoretic. Why would the transfer of glucose plus insulin be a faster mechanism than the simple diffusion or passage of fructose through the cellular membrane from the surrounding metabolite-loaded intercellular fluid and into the cell without the intervention of insulin? I am not aware of any report which satisfactorily clarifies this point one way or another. On the other hand, my own clinical experience, to be presented in other reports, has consistently shown, during a period of over five years of careful and methodic observation, that the prolonged and steady inclusion of fructose in the diets specially prescribed for a large number of patients with diabetes of all possible degrees of severity and complications has resulted in sustained objective and subjective clinical improvement to degrees not possible in them previously, or in the controls, by any other generally established method of treatment.

#### Summary and Conclusions

Failure of ingested fructose to relieve the signs and symptoms of hypoglycemic reactions in diabetic patients receiving insulin is presented as

presumptive evidence that most of the ingested fructose is absorbed into the human blood stream as such and is not converted to glucose by the intestinal mucosa as has been generally believed.

A series of graphs, depicting paired oral glucose and oral fructose tolerance tests performed a few days apart with each subject being in an equivalent metabolic state, shows that in three nondiabetic subjects, 22 diabetic patients and one patient with hepatic disease, postabsorptive hyperglycemia was absent or significantly lower after the ingestion of fructose than after the ingestion of glucose. Glycosuria following the ingestion of fructose was also absent or significantly lower than after the ingestion of glucose. This finding may be taken as additional presumptive evidence that all fructose is not converted to glucose by the intestinal mucosa.

Apart from its significance as an emergency stabilizing factor of the blood sugar level, the importance of the role played by the conversion of either glucose or fructose to glycogen has probably been overemphasized. According to Stetten and Boxer,<sup>8</sup> only 3 per cent of the total sugar ingested in 24 hours is stored as liver and muscle glycogen.

A discussion of the current theories of carbohydrate metabolism offers a possible explanation of the role of fructose as a major source of caloric energy in the diabetic patient with a possible reduction in the need for supplementary exogenous insulin.

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# Myasthenia Gravis

## Part II

*By A Doctor Who Has It\**

1903 - 1906

There is a story of a frightened soldier running away from battle, who runs into his general. The general demanding an explanation, the soldier stammers out as an excuse, "I've lost my regiment!" to which the general answers, "Get in anywhere. The fighting's good all along the line." That applies to fighting a disease of which as yet we know neither the cause nor cure. Doctors having such disease could get in anywhere and fight and not look for regimentation. "To observe and to record for mankind is our first principle."<sup>1</sup>

Let us talk about myasthenia gravis because I have it.<sup>2</sup> I would divide patients with myasthenia gravis into three groups and, granting that his condition will change, any patient will still be in one of these groups unless he has a remission:

- I. Patients whose disease is so controlled with modern therapy that they can live nearly normal lives.
- II. Patients manifestly handicapped, yet who, when protected against the slightest external stress known to precipitate collapse, are able to be somewhat active in their rooms in wheel chair or bed and usually with, sometimes even without, medication, might survive many years.
- III. Patients whose disease is acute and severe.

Whether or not those writers are correct who have dictated that every patient with myasthenia gravis should be kept absolutely quiet in body and mind does not, I believe, depend so much upon the diagnosis of myasthenia as upon the degree of the disease that places him in one of those groups. Obviously, his condition may change him from one group to another. But when he has strength for some activity, as in the first and second groups, he should be encouraged to select activities and interests to which, by avoiding overdoing and by observing regular periods of rest, he can heartily devote some time. "Isolation and a vacuum of thought often lead to a decay of the total personality."<sup>3</sup>

Whether the undiagnosed illness taking me out of the senior class of high school for three years was myasthenia gravis and thereafter I enjoyed a 40 year remission, I am less in a position to affirm than to tell what I remember. It was near the beginning of my catamenial life. I was almost 18 when taken sick. Recent studies show that the most common age of onset of myasthenia in women is 21, although in men it is 71.<sup>4</sup> Headache came on in school, vivid to memory for I had never had a headache before, but unrelated to the chief complaint which was generalized muscular weakness symmetrical in trunk and extremities except for painless lameness in the left leg. Weakness confined me to bed for two years. There were mild dyspnea without pain, ptosis and intrinsic ocular manifestations, but no fever or atrophy. Two general practitioners, one, Dr. William Sabin, cousin of Dr. Florence R. Sabin, one my cousin, were at first in charge. In Albany County, New York, early in this century, if a disease was not understood, mild malaria was considered, but quinine always made me worse. Two neurologists then came.

The Johns Hopkins Hospital had been opened in 1889 with Dr. Osler as first choice to head the department of medicine. He had steadily turned aside all temptations to private practice,<sup>5</sup> and cases of myasthenia gravis had not reached his medical clinic in numbers before 1904 when he had "dumped the manuscript of his great work on medicine into the lap of Miss Revere," who later became Lady Osler. So myasthenia was unthought of. "Up to 1895 all reports of cases had come from England, Germany or Austria . . . soon case reports began to come in from France, from Italy and from America." "From 1900 to 1934 the disease was considered uncommon and usually fatal,"<sup>6</sup> whereas, with me, after two years in bed, spontaneous recovery occurred without other sequelae than volitional tremor, painless lameness and poor eyesight. I wanted to return to school, but the doctors advised my parents to keep me out for a third year.

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## 1906 - 1946

During what, for brevity, might be called a 40 year remission, I developed tricks concealing sequelae. Tremor preventing my ever making a correct blood count as a steady hand is necessary for drawing blood exactly to the graduation on a scale, I became resident physician in the student infirmary of a university hospital where all laboratory services were provided. As to eyesight, the family had read to me during the sickness. In college and thereafter, I engaged readers on the advice of Dr. George M. Gould, ophthalmologist, lexicographer and incidentally a lifelong friend. About 1920 to 1925 there was double vision at night if I was tired. There is lack of proof that at that date many persons knew either that quinine made myasthenic patients worse or that double vision might suggest myasthenia. I knew that had I mentioned double vision in that coeducational university, I would have been accused of drinking. I never drank, but denials would have done no good. My resignation would have been requested and recommendation to another position refused.

We adjust to and then get used to a host of things in life, later pushing adjustments far back into the subconsciousness, from which they nevertheless burst out to function in later times of emergency or hurry. So, more of this burst out later. Meanwhile, as deans of universities search for doctors willing to lecture, I was appointed a professor, a position which minimized my practice. Aphonia developed during a sporadic attack of influenzal pneumonia. Passing after convalescence, I thought it insignificant.

If statistical data are available revealing the average suddenness or slowness of advance of myasthenia, whether a first attack or following remission, I have failed to find such data. Advance in my case was at a snail's pace, covering eight years from the beginning of attacks of subacute pharyngitis in 1938 until the diagnosis of myasthenia was established in 1946 and covering 14 years until pharyngitis revealed itself as nature's effort to compensate for advancing laryngeal paralysis discovered on examination of vocal cords in 1952. Even prior to 1938, conscious of vague malaise, I was admitted to a hospital in the summers of 1936, 1938 and 1943, to be discharged each time labeled a psychoneurotic.<sup>7</sup> Doubtless this was the only diagnosis which could be made *if* clinicians are obliged to diagnose each case ignoring the possibility of preclinical symptoms.

Later, the medical director, learning that I had myasthenia, wrote that he had "never seen a case." This is disputable for during the 40 to 50 years of his practice, he may have seen many cases, making a diagnosis of psychoneurosis in each one. With the exception of laryngologists who could not relieve me, physicians did not consider the pharyngitis significant. An article appeared in a medical journal implying that repeated complaints of subacute pharyngitis suggested a psychopathic personality. Experience teaches concealment of unusual symptoms.

In the summer of 1945 came the first attack of generalized muscular weakness. I no more recognized it for what it was than would any other patient. Having gone to the Neurological Institute in Montreal to study electroencephalography, by the end of Dr. Herbert Jasper's course, I had been much on my feet and was fatigued. Thus it came about that, at the last moment, conscious that I was too sick to travel, I surrendered my ticket for a long-planned steamer trip, and the laryngologist who had treated my throat for six weeks referred me to a bed in the Royal Victoria Hospital, prescribing throat irrigations and, although the basal metabolic rate was within normal limits, desiccated thyroid.

Other detail is inserted here to emphasize a parallelism between sickness and weakness in myasthenia. Some patients say that they are weak. I should not have said so at that time. Asked if I were weak, I should not have known enough to say yes. I should have said as my chief complaint that I was sick all over. Persons differ, and intellectual backgrounds produce differing responses to the same questions. Although I have never done any physical work, yet, since 1906, if overactive, I have had first a muscle joint sense<sup>8</sup> and next a muscle sense, indicative of exhaustion. Other patients may have had the same although they expressed it differently. I still have this response with the more severe attacks of myasthenia. There must be times when a confusion of semantics between sickness and weakness confuses and increases diagnostic differences for doctors.

No sooner was I discharged from the hospital 10 days later than pharyngitis recurred. Thyroid I could not take for as often as it had been prescribed, it had always caused a rapid heart action. Having two weeks vacation still ahead, I used that for rest and was in my office at the State University Health Department by the opening of the fall term. The next attack of generalized muscular weakness I experienced on horseback after



not a hard ride but a long distance ride which Thanksgiving vacation had permitted. Again I became sick all over. Never in my life able to mount in the usual way by one foot in the stirrup and springing up into the saddle, I always needed a mounting block. So, first I located a suitable stump in the forest wherefrom to remount, then dismounting, tied my horse and lay down until able to ride home.

Other problems arose. The painless lameness increased. Sitting at my desk short of breath after office hours, I suddenly remembered having had exactly the same type of lameness in the left leg and dyspnea without pain when taken out of high school, and I thought, I got well of that and I will get well of this. After four admissions to the hospital, however, for being overtired, on Jan. 1, 1946, which was my sixty-first birthday, I wrote my resignation from the university. It was not accepted. I worked little, and talking became difficult with a sense of a mass forming retrosternally, near the suprasternal notch, but disappearing within an hour if I could stop talking. Experiences inhibited me from revealing bizarre symptoms. Whether this bizarreness was, or was not, related to the thymus gland, no glandular tissue was evident on x-ray examination.

#### 1946 - 1958

Two doctors now told me that I had myasthenia gravis, while a third told me that I had not and a fourth that I had. I had sought none but the first, each directing me to the next. Six years later, the dissenting third physician agreed with the others. Did I unintentionally do things preventing him from earlier diagnosis? Yes, I did many things—a "Comedy of Errors."

First, he was the only doctor ever to ask about my eyes, and he was in a hurry. I could not help answering no as the past history of double vision had demanded concealment; as it did not recur until years later in an episode of four interns having eight heads; as blurring of vision precipitating me into fear that I was becoming blind had ceased upon my retiring 14 months earlier and had so relieved me that I was able to forget all about it. My answer was no. Secondly, uninstructed as to possible results, I was given, intramuscularly, probably Prostigmin. Ignoring side effects, I felt stronger as I had not felt upon being given its analogue orally. I opened my mouth to say I was stronger when something interrupted both of us; so my words never got out.

Thirdly, in the myographical, later called electromyographical, laboratory, I was given the ergograph test. Instantly I saw two ways of handling the hand bulb, either with utmost strength exhausting one the sooner or conservatively with just that degree of strength one could command longest and would use in ordinary work. I started to ask which and then thought, if they gave no directions, I must not ask. I must do this as I would any work. So I did and continued the same system whenever given the bulb. The last time, which was six years later and in May 1952, generalized myasthenia began coming over me while seated with the bulb. My hands were my strongest part. I whispered to the attendants that I was about to fall and asked them to let me lie down. Although hearing, as they stood near watching the bulb tracing, they did not believe. Perhaps the tracing misled them. They paid no attention until too late for me to be able to cooperate; so I nearly fell in the combined struggle of attendants and myself to get onto the stretcher.

A number of doctors have written that there is no pain in myasthenia gravis. Have they had it? When generalized myasthenia spreads over the whole body and there is something demanding to be done, as getting on that stretcher, it is not painless, not miserable; it is agonizing. The supreme effort to control the body without the ability to do so, the breathless struggle like that of the drowning man—all is totally unavailing. Of course, if the patient, supine in bed where the law of gravity is outwitted and confronted with nothing which demanded being done, were asked if he suffered pain, despite muscle joint sense and a generalized sense of something wrong over the whole body, he might truthfully answer no, not exactly pain.

Have those writing that myasthenia is painless, had it? Having it, have they tried to cooperate to help those caring for them? If not, they have never experienced the magnitude of contrast between struggle versus strength, evident when an hour later and having been given Prostigmin, I sat comfortably in a wheel chair before the doctor in his office and listened while he told me that I did not have myasthenia gravis. He was innocent of what had just gone on in the laboratory. I asked, "What have I?" He answered that he did not know. That night he directed others to re-examine me in the laboratory and later reported that indeed I did have myasthenia gravis. The laboratory test was done with more precision and now it was read as positive. Thus the con-

firmatory tests of myasthenia are not always easy and require attention to detail. This doctor, who had maintained the negative position for six years, described how laboratory mistakes had occurred. The diagrams and percentages involved I was incapable of seeing; so I cannot repeat his careful, cogent explanation, nor do I yet know the right way to handle a bulb.

Returning to my mistakes back in 1946, I had made a fourth and fifth mistake in the drug tests. As to quinine, because after the first dose in the morning I could still walk comfortably, I was overjoyed and confident. The fact that that night I almost fell, and was saved by a woman's arm, I rationalized by its occurring at night. Too weak then to improve my already written optimistic report, next morning I was stronger and let the report stand. The doctor questioned whether I was sure that the report was correct. I needed but to shake my head in the negative; yet, feeling morning strength, I could not do so. Then came another drug test. Weak during it, I looked at an inviting flight of steps and wanted to sit down. Reminding myself of the times when I had been weaker and that it was now afternoon, again I failed to make a negative report. Thus I unintentionally did things preventing that third doctor from making an early diagnosis. During the days of that examination I was told that a psychiatrist was one of the examiners, and an appointment was made for me to meet him. Following a short interview, he gave me a long series of questions requiring hours to answer in writing and thereafter reported that no psychosis was uncovered.

Chronologically, beginning in 1938, my problem had started with one and by 1948 had presented all three of the critical neurologic symptoms involving talking, seeing and swallowing.<sup>4</sup> They had developed in that order. During the 10 year interval had come also weakness of the muscles of the extremities and trunk with attacks of exhaustion and malaise. In 1947 a friend had advised me, "Do not smile so broadly. You look as if you were sneering." It was something close to risus sardonicus. Yet, if I could avoid talking, I could do well. Each summer I could be taken by car from Boston to a nursing home in Maine until 1953, when I had become unable to dress, was falling often, and was too weak to leave my room, with aphonia, dysphagia with regurgitation, and ptosis of the lids, jaw and wrists gradually increasing with decreasing basal strength. As aphonia advanced and I ceased trying to talk, subacute pharyngitis ceased, recurring

only after whispering, or, when I had a hymn in mind, after humming its tune. There had been gradual lowering of vocal tone, but neither nasal tone, hoarseness, nor huskiness, until 1958 on a day when, forced to whisper, I could not produce a sound but one hoarse croak.

From 1952 onward, the giving of outward attention became yearly more difficult. Its problems magnified by my not understanding them and therefore being often baffled and humiliated. Outward attention, the power to focus on some external aspect of the world of reality, away from the mesial plane of the body, demands the use of many voluntary muscles which can become not merely quickly, but at times all of them instantaneously, paralyzed. Outward or objective attention, therefore, is that which patients with this disease become increasingly unable to give. At the same time, they may often give subjective attention for long periods with comparatively little effort because subjective attention is maintained more mesially and demands use of fewer voluntary muscles. Thus the cue to understanding patients' activities resides in remembering the marked contrast between those two kinds of attention.

Moreover, since patients can become greatly puzzled and humiliated at themselves, they profit by their doctor's sharing with them some understanding of the facts which cause them to fall paralyzed upon the approach of a person, yet permit them a considerable range of activity when alone. Years ago, I was standing when my best nurse quickly entered the room. The instant I turned to greet her I fell flat. That instant she turned and walked out, saying she would "not help anyone who would hurl herself down." I never tried to explain for I did not then know why it was that I could stand when alone, yet fall the instant anyone entered my room and I turned eyes and head to greet them.

Circumstances and temperament obliging one nurse to move and speak hurriedly in contrast to another who is slow and gentle reflect unfortunately against the patient. Unintentionally, a hurried nurse makes a weak patient suffer. Every normal person is suggestible. The instant that the hurrying nurse appears at the door, a sensitive patient catches that contagious suggestion of hurry and prepares to cooperate with speed. Myasthenic collapse that advances gradually with advancing disease may produce a universal muscle joint sense<sup>8</sup> with consciousness of malaise



but without pain. Therein lies the origin of the report that the disease is painless.

Upon the other hand, collapse that advances suddenly by attention to hurrying persons passes over the patient in one instant and produces a universal distress which may be agonizing. Even though I have already prepared myself by lying supine when the hour of the hurried nurse's advent approaches, recumbency is not enough. Ptosis, dyspnea and the other myasthenic phenomena strike at once when the hurrying nurse asks a simple question. The patient, knowing that he can whisper to the slow nurse, overconfident of strength, believes he can whisper the brief answer to the hurried one. As far as possible he turns to her that focus of outward attention he would instantly give if well, but to which his muscles make no response.

There is now an increasingly miserable muscle joint sense for sensation is not paralyzed in myasthenia. The total force of central and peripheral systems beating upon the margins of negative dead zones struggles to get important messages delivered. Getting no results, the force but increases its demands. Whereupon, so many stimuli pour through the existing synapses of less paralyzed muscles that arms and hands fly into futile, flail-like spasms while, near the paralyzed larynx, unparalyzed pharyngeal musculature produces the "crow" suggestive of whooping cough. Midst such a condition, a sick person may have but the faintest idea of what a hurrying person, standing up and talking quickly, has been saying. The members of the family need to be informed that such episodes are by no means painless. They are beyond the imagination of those not experiencing them. They take a great deal out of a patient. He does not recover immediately. Thus there is a contrast in energy expenditure between contact with a person obviously hurried and with one of leisurely carriage. There has been talk about "spanking getting into a child's muscles." In a parallel way, haste gets into a myasthenic's whole system with equally startling, miserable and memorable distress.

How much did I know about the import of my symptom complex? Very little. Not until 1956 did I see in *The New England Journal of Medicine*, in the discussion of a case,<sup>4</sup> that "respiration and swallowing are the only vital functions affected by myasthenia," but also that the medullary muscles of talking, seeing and swallowing are considered critical muscles, so important that when the time of the final episode occurs,



Fig. 1. — Thirteenth Year

Dr. Robert S. Schwab affirms that "if those critical muscles are not involved, the patient does not die *with* myasthenia." No physician, least of all myself, recognized the import of my long-involved "critical muscles." As I, a physician who has it, could not recognize their import, I could never criticize others for missing the diagnosis.

This section should not be concluded without drawing attention to some of the many problems. Myasthenia gravis is a grave fatal disease of which as yet we know neither cause nor cure. At times it may precipitate to termination within a few weeks. Usually it progresses slower under helpful modern therapy.<sup>9</sup> Its symptoms occasionally develop so gradually as to confuse a physician. Which subjective complaints of a patient can a doctor ignore? How give a clean bill of health merely on a basis of absence of objective signs of disease? What we have here, then, poses perplexing problems for the clinician.

Secondly, when a patient has long had the disease, why should it affect the muscles of the head and trunk more than those of the limbs? I could stand and take a few steps were it not that they would be followed after some 15 minutes by dyspnea which might continue for an hour. Dyspnea is not the point. The point is feet. Why do the feet, which are most remote from the heart and brain and to reach which nerves traverse the longest distance, continue functioning when the diaphragm is failing? Thirdly, difficult though it be to discover its import, yet there may be significance in the fact that the average age of onset of myasthenia gravis in women at 21 years is about as soon after their reproductive life begins as the average age of onset in men at 71<sup>1</sup> is after their reproductive life may have ended. Many questions await answer to the ultimate question: What is the cause and cure of myasthenia gravis?



### Helps for Patients

What I hope to do is to scatter ideas, some of which here and there might help one patient, some another—more or less simple suggestions encouraging the patient to take care of his body, mind and spirit, so that he may live as long and happily as possible, develop his own helps fitting to his needs, have an interest in the world and its people and enjoy the zest of life. It is impossible to arrange helps in sequence of need for who knows in which stage of myasthenia gravis he may be? "It is estimated that there are approximately 30,000 patients across this country, including those who have been diagnosed and those who are undiagnosed at the moment. It may be the figure of undiagnosed ones will run a great deal higher, but we are very conservative in our estimate per the rules and regulations as laid down by our Medical Advisory Board."<sup>10</sup>

During sickness some persons ascend in the scale of evolutionary life; others slip backwards. In health, persons may have continued so calm under irritating conditions that nurses asked, "Doctor, do you ever get mad?" In sickness some of those same persons may have become so excitable and irritable that, struggle as they will to control themselves, they fail. Why? The reason is that they are subjected to what we call psychophysiological strains with deep physical and mental roots. We can neither give all the reasons, nor solve the problem so as to guarantee relief, but we have some information.

First, take physical aspects in the light of the history of evolution. The wounded animal is irritable and to such extent that his actions may be in violent contrast to his actions in health. In him and in us that reaction comes from the glands of internal secretion which have developed to protect us all against injury and sickness. Those glands constitute the internal army that fights danger. Struck dumb, therefore, by a degree of weakness which we do not have muscular power to combat, we tend to become irritable and childish and even to revert to weeping.

The soul sleeps in the vegetable, dreams in the animal, but awakes to consciousness in the man. Secondly, therefore, take the psychological aspects in the light of our humanity. We struggle to achieve a better adjustment for we know it to be our duty. Duty is what is owed by our limited, individual ideals to the ideals of our social group. Our individual ideals, however, lack bricks and mortar necessary to resist such hurricanes as re-

peatedly burst upon us in myasthenia gravis. Ideals can be strengthened by painful, difficult reinforcements of the complex character of the self, laying hold of all available material, intellectual and spiritual, offered by our environment—by our doctor, nurses, relatives and friends. I set the doctor first, not because of being a doctor but because our doctor helps us most.

The problem of life has always been to idealize the real and to realize the ideal. We can and we must, when necessary, reconstruct ourselves. This disease so often gives us such long life after it begins to gnaw away physical strength that we have reason to increase our mental, moral and emotional strength. With inactive body, stability is wholly dependent on activity of mind and spirit. "What constitutes the difficulty for a man laboring under an unwise passion from acting as if the passion were unwise?" The difficulty is mental. It is the difficulty of getting the thought of the wise act to stay before the mind at all. When any strong emotional state is upon us, the tendency is that by a sort of selective affinity the images that offer themselves are such as are friendly to the emotion. If thoughts of wiser acts offer themselves, they are instantly smothered and crowded out.

Our cue in this state of our lives, accordingly, is to draw up workable plans both intellectual and spiritual so to manage our lives that we remain calm under irritating conditions.<sup>11</sup> To that end we select what advice, books, music, mental images and other aids that we decide will help. We iterate and reiterate our intention, morning and night, just as waking in the morning, just as going to sleep at night, those being the two times of day when we have closest access to the sub-consciousness which will direct improvements in our ideals of duty.

Later each day, we should be devoting all our attention to those other activities and interests to which, avoiding overdoing by observing regular periods of rest, we can heartily give some time. "Isolation and a vacuum of thought often lead to a decay of the total personality."<sup>3</sup> On the other hand, by regularly giving attention to interesting work—it makes no difference whether with draughtman's board before us we are sketching plans for a cathedral, or with needles in hand knitting our baby's socks—our subconscious life will continue directing and integrating within our total personality those higher ideals and potentials of duty which we continue constantly

suggesting to it on returning to consciousness mornings and departing from consciousness nights.

**OUTWARD AND INWARD ATTENTION.**—Outward attention is harder to give because it demands more muscular effort than inward attention. In health, we are “geared” to it. In this disease the gears are broken. The very name, myasthenia gravis, translated means “a muscular weakness which is grave.” By understanding the following we can understand ourselves: So far as is known up to the present date, the center of the disease is at the junction between nerves and voluntary muscles. The impulses which in health pass from nerves to muscles, in myasthenia gravis pass poorly or not at all. The more outward attention we give, the more muscles we use and therefore the more fail us. They do not fail because we use them. Use them as long as they will work. They fail because the disease advances.

Physiologists, using scientific words and referring to objective and subjective attention, have long known that outward attention demands the greater muscular effort. Yet, as suggested in a preceding paragraph, when we are too weak to give outward attention, it may often be our good fortune to be able, by being alone, to give subjective or inward attention to drawing board, knitting needles, or what we will. We do not overdo. That would make myasthenia worse. Neither do we let ourselves wither on the vine while still enjoying strength to do *something*. In giving inward attention we use our hands, often our strongest parts, look mostly straight ahead and breathe quietly, using perhaps a twentieth of the muscular power that would be called for in giving outward attention.

So, it comes to this: Outward attention depends considerably upon what we give socially to others. It is, therefore, reduced to a minimum when we are alone. Using an old description, we each have one of the three personality types. Each of us is either an introvert, an extrovert, or a mixed introvert-extrovert. It is easy to see that introverts would be the best qualified to adjust to myasthenia gravis for they do not need society, but can entertain themselves very well alone.

**AVOID OR DEFER PAIN.**—The bones of most persons lose calcium and begin crumbling as years advance. The process is hastened in those invalided. So, for that and other reasons, begin now ingeniously inventing tricks that might prove helpful. Within limits of strength regularly, daily except Sundays, exercise. Physiologically, we need exercise Sundays as well as other days. Neverthe-

less, the fact is that by keeping Sundays and holidays, as far as possible, free from all self-imposed duties, we can keep the days of the week distinct, separate and clearly identifiable in our minds. It is an ideal method of orientation.

Remember, exercise is slow. We do not drive ourselves. That would make us worse. We exercise gently all we can. Toes, feet and ankles would be apt, in disuse, to pain first. Be undaunted for you can arrest that. Systematize the time of day. Also, count the number of times devoted to problems. Every bed has two sides, right and left, plus the middle. In the nights sleep where you will. In the days alternate weekly the three areas in which you will lie. Alternate also the sides of the bed which you get in and out of as long as you are able to leave your bed. As long as you are able to stand for a few moments, you have the ideal way to correct pain in the feet. (As an aside, if your healthy relatives complain of foot pain in one or both feet, even if it be from fallen arches, they may welcome your instruction.) If you are unable to get out of bed, you can still perform your exercises from your back in bed. Imagine yourself standing close to a wall so that if necessary you might lean against it avoiding a fall. Very slowly, rise on your tip toes (even in bed you can imitate the motions) tensing, as would occur if really on tip toe, the muscles across the dorsum, that is, the back or top, of the foot. Then, as slowly, go down to rest on the whole length of the feet.

Now slowly roll over onto the outer edges of the feet, then holding yourself on the outer edges, curl up your toes under your feet just as tightly as you can. Do all that slowly, but using what strength is yours. Next, undo the process. Slowly roll back onto the flat of the feet. A novice does this but once a day for a time, accustoming his muscles to an action he could perform twice a day after a few months. By doing the thing he has the power and he escapes the pain that can beset unused muscles.

Secondly, pain in your back can come from poor posture which you innocently maintained when up and about, or in bed sick. Poor posture exaggerated the normal curves of your spinal column. Now, do something to avoid deepening the exaggerations. Can you lie on your back on the floor for a time daily? I slept on the floor every night for six months and thought it miserable at first, but got so used to it I actually disliked to resume sleeping in bed, although of course I did so. In any event, have a bed board under your mat-



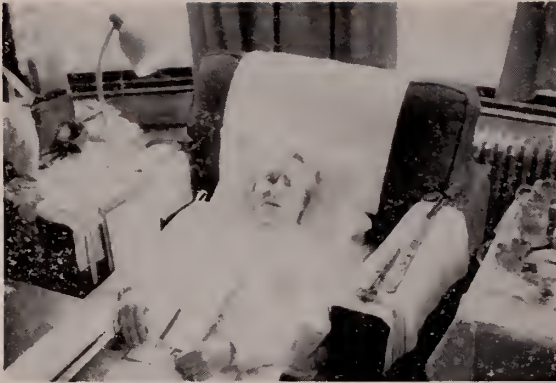


Fig. 2. — Helps for patients.

stress in bed. Day and night minimize the curves where sensitive nerves can be pinched between your vertebrae in your spinal column. Further, and this you can manage by persistent self discipline, in acute pain, you will notice that you tend to stiffen, thereby increasing the pain, particularly in the back. Discipline yourself to relax. Relaxing relieves the pressure which has pinched a multitude of nerves and caused breath-taking pain. After you grasp the trick of instantaneous relaxation, you will be happy at discovering that you have conquered something.

**COMFORTABLE SHOULDERS.**—When no longer walking, play a trick to maintain health in your shoulder joints. Occasionally, every 24 hours, stretch your arms well down at your sides, enough to imitate what would be the drag of their weight on shoulder joints. You know what a drag would occur with arms at sides when walking. It would be the normal gravitational pull. Imitate that pull. Thus maintain ability to sleep comfortably upon either side free from pain at night.

**BATHING.**—If it is such a strain when a visiting nurse comes to bathe you that upon those days you cannot swallow thereafter, be patient with yourself. If it happens regularly every time after you have been subjected to strain, write to the nurse who prepares your tray next following such strain. Tell her that you cannot take any liquids for the remainder of that day, but may manage a dry meal. Dry food can be swallowed when liquids cannot. Drinking liquids and swallowing dry foods are two “different physiological processes.”<sup>12</sup> A constricting ring toward the lower end of the tube through which your food passes on its way to your stomach needs to be “opened earlier in drinking than in swallowing” dry food. So it may become paralyzed earlier and fail to serve you. What we call muscles of degluti-

tion are paralyzed while muscles of regurgitation are not. Dry foods help you escape sudden, uncontrollable spasms of pain, when liquids gone down cannot be swallowed and may be suddenly violently regurgitated.

Knowing now when *not* to drink liquids, do you know when *to* drink? And how much? Drink when rested. Begin when you first waken in the morning. Drink a great deal. Inactive persons need much water daily to avoid formation of gallstones and kidney stones. Never let the fact that ample water demands frequent urination lessen your daily intake. I can cheer you about the difficulty with swallowing by telling you that it may pass. Around 1947, a year after my disease was diagnosed, I had trouble swallowing. It lasted no more than three weeks and did not return for years.

**APHONIA.**—If voiceless, you have discovered how the most ordinary transactions of living depend on speech. When hands are not strong to write legibly, you are in a predicament. If you have a friend who had cancer of the larynx and now wears an artificial larynx, you may wonder whether that could help you. Probably not. With throat muscles too weak to control vocal cords, you have already used up available esophageal speech. The electrolarynx is called difficult, would be a great strain and perhaps you could scarcely, if at all, produce sounds with it. Should your mind demand more information, ask your doctor. He might tell you that you could write to the Aurex Corporation, 511 Fifth Ave., New York, N. Y., and put your question to them.

#### What Price Voice?

Experience teaches every man  
To throw his voice as far as he can,  
To help a good friend hear.  
So, man grown weak,  
Will still try to speak,  
To throw his voice out, clear.  
But O the distress, the misery,  
Of this weakness of the body.  
What profaneness may ensue  
If his habit of health he pursue.  
Every muscle fails;  
His spirit wails.  
It is not well in the bodily shell  
If across his bed breath he propel.

We therefore resort to writing. We find a number of stages of need, evoking a number of differing materials: (1) Ink will not flow uphill when we



write lying on our back, in bed, but with pen rolling out of hand, ink will flow readily over sheets and pillow cases. (2) While any pencil serves at first, the time comes when we must have the softest of ordinary pencils in order to make visible marks continuously. (3) Next, we are told that instead of on white paper, our pale marks will show up more clearly on yellow paper. So we order it in sheets  $5\frac{1}{2}$  by  $8\frac{1}{2}$ , a dozen pads at a time. (4) Then, the softest ordinary pencils failing to write after a few sentences, we abandon them for larger pencils easier to hold, less apt to roll out of fingers and actually making a definite mark. They are "Blaisdell China-Marker Black 173T." The writing core, many times greater in diameter than the core of an ordinary pencil, conceals our fine tremor, but our writing has now become so large as to make our smaller paper often useless. We cannot make a mark on a magic pad. So, (5) we order "Canary Railroad Manila" copy sheets,  $8\frac{1}{2}$  by 11, 500 sheets to the ream. We use reams of it. It becomes too small to accommodate our coarse writing. Thereupon<sup>6</sup> a pharmacist sends us reams of the largest yellow paper,  $8\frac{1}{2}$  x 14. Strangely and happily, even when obliged to use a Blaisdell pencil we may find that we can still type on the smallest, lightest touch machine. Even when the pencil rolls out of hand, there may be something that helps myasthenic patients in the alternating-contact-relax-writing of a typewriter.

**THE LONG YAWN.**—That is simple, yet strange enough to puzzle you, should you experience it. I never heard of it, never read of it, but having it, needed to give it a name, as it may enter the experience of others. Early in the period after you become unable to dress, when lying down relaxed, you may find yourself trying to yawn but the yawn refusing to come and be over with. Then you go through any number of sequences of ridiculous experiences of lying with the mouth wide open, struggling, trying to complete repitious reflexes of almost yawnless yawns. You gasp, trying to get done with it, but as soon as it really comes, the reflex repeats itself over and over, until that urge exhausts itself. Again and again it reappears in selfsame ridiculous fashion on other days, ceasing entirely with me after some six months or a year, to recur in a minor way now.

**DENTISTRY.**—You need to have your dentist call on you as often or more frequently than when you called on him. Teeth chip off in most prominent and offensive places, decay, crack and break during incapacity. Happily though, you will be spared what we who are sick before you suffer

because fortunately dentists are now becoming conscious of needs and are arranging for home care. When you do not know one near your residence, ask yours to refer you to one near by, should he desire.

**WORK.**—If we are able to discover some things which we can do and enjoy, we forget our limitations and recover our zest of living. Making Sundays, also perhaps Saturdays, different, not all days will be alike. As long as we are able to lift a finger lying on our back, we work with our own individual, systematic regularity. Time goes like the wind. I can assure you of it, for I can scarcely believe that it was in 1946, in San Francisco, California, where I was attending the annual session of the American Medical Association and feeling sick all over from walking—whereas in the three day Pullman trip from Tallahassee, Florida, to San Francisco, I had felt well from riding—I was told that I had myasthenia gravis. I can scarcely believe that that was 12 years and more ago. Time has gone like the wind.

### Summary

The writer, when a student in high school, had a three year sickness suggestive of myasthenia. She again, 40 years later, had similar symptoms; was in 1946 given a diagnosis of myasthenia gravis; is now in the thirteenth year of this attack; and devotes the last third of her paper to suggesting helps for patients. These beginnings are offered in the hope that doctors now in active practice will contribute more helps.

### Addenda

This article was submitted for publication before the announcement appeared of Dr. Kermit E. Osserman's book, "Myasthenia Gravis," published by Grune and Stratton, New York and London, 1958. Dr. Osserman has produced an exhaustive text worthy of study by all doctors in charge of patients with this disease.

Also since this article was submitted for publication, potassium chloride, which helps but few, has been prescribed for me. It has practically cured my myasthenia gravis of skeletal muscles, but its early relief of the more important bulbar muscles has not been similarly sustained. This latter fact raises a question which I have not found a single neurologist able to answer, namely, what is the difference between these two muscle groups as regards the cause and cure of myasthenia gravis? Why has potassium chloride continued helping one group for the past six months, while failing with the other group within two months? I solicit answers.

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7. Those dates totaling three times are correct, but require explanation because, in the article published in 1956, "twice" appeared, instead of three times. I could not bear to humiliate an aged director of the Diagnostic Clinic who has since died, nor to pollute the minds of the laity in an article written more to point them the way to peace and contentment than written for the profession.
8. "According to E. G. Boring's 'Sensation and Perception in the History of Experimental Psychology,' the notion of a muscle sense was accepted generally after Bell argued for it in 1826. The term is still used by psychologists, although 'kinesthetic sense' seems to be somewhat more fashionable at present. Certainly it is accepted that there are sensory receptors in muscles, tendons and joints which are stimulated by movements or muscular contractions. Dr. E. B. Titchener made great use of the muscle joint sense in his thinking." (Quoted from a communication from Prof. T. A. Ryan, Chairman, Department of Psychology, Cornell University, Ithaca, N. Y., Aug. 7, 1958.) "Professor Titchener stood for the 'pure' scientific psychology of the generalized, adult mind. . . . He thus became the exponent of the school of structural psychology which opposed functional psychology; in later times he represented the opposition to behaviourism." Encyclopaedia Britannica 22:252c, 23:816b. 1958). That explains the minimal use in the United States of the expressive phrase, muscle joint sense.
9. (a) Information concerning therapy is obtainable on request addressed to: Medical Directors, Myasthenia Gravis Foundation, Inc., 155 E. 23rd St., New York 10, N. Y. Those Directors are in a position also to indicate, on request, localities where hospitals across the United States, in Canada, in Mexico, and elsewhere, are conducting myasthenia gravis diagnostic and treatment clinics. Moreover, "a second International Symposium . . . was planned for April 1959." Reports will be available from the Executive Director of The Foundation, Mrs. Agnes K. Peterson. (b) "As Dr. H. R. Viets has stated, the mortality rate of myasthenia has been reduced to about 10 to 15 per cent by modern therapy, yet as far as we know these drugs are symptomatic therapy and do not influence the disease process directly. They are in no way concerned with the development of remissions. . . . Fatalities continue to occur." (Quoted from Gammon, G. D.: Symposium on Myasthenia Gravis, Foreword, Am. J. Med. 19:655-657 (Nov.) 1955.
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# An Evaluation of Blue Shield

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Before one undertakes to assess the future, it is advisable to review briefly our origin and progress to see whether the fundamental purpose for which Blue Shield was created has been realized or how far toward that realization we have progressed or deviated.

A little over 25 years ago we were in the midst of a severe cyclical depression which had come to be considered a necessary part of our capitalistic system, the penalty for overproduction and a necessary result of reckless abandon in a period of postwar boom when spending was free and the bubble of overspeculation had already burst and spilled its unfortunate victims into a morass of despair and confusion. Farms had been foreclosed, homes were lost, and bank failures were the order of the day.

Born of this confusion and despair was a man classified by some as a savior and cursed by others as a despot who started the trend to the left and began our journey down the road to socialism. That some of the results of his reign have been blessings no one can deny. The federal insurance on bank deposits and the regulation of the securities markets by the Securities and Exchange Commission are undisputed benefits. The idea of centralized control in the federal government and the paternalistic philosophy that many aspects of human life are the direct concern of the federal government were new and, to many, questionable departures from the age-old concept of democracy.

The philosophy that the federal government has no place in matters which should be left to and can be better administered by local or state governments or by the individual is still, I am sure, the inordinate belief of many of us here today.

The situation today is quite different from that of many years ago when President George Washington visited Boston. On that occasion the day was cold and rainy and the President was kept waiting in the raw outdoors until the local politicians could decide who was going to march where in the parade. Further delay was brought

on by Governor John Hancock, who did not see any reason why a governor should go out and kowtow to a President, and so he did not even show up. Now the situation is reversed with the governors going to Washington to try to get some of their tax money returned to their respective states.

Associated with the depression there were many unfortunate individuals who suffered the humiliation of inability to finance an illness and who became subject to charity care by both hospital and physician. Large wards of so-called "service patients" were the rule, and many of the older physicians spent and expected to spend the entire morning caring for those people. Nor was their interest and devotion to those patients any less than that accorded the more fortunate persons who paid for their services and thereby had the right to demand the greater attention.

## Demand for Public Protection

It was under these circumstances that the push for widespread protection of the public by a form of government medicine began and appeared ready to flourish. You are all familiar with the Wagners, the Dingles, the Murrays and the Ewings. The private system of medical practice in England was radically changed overnight and this occurrence created additional impetus for the proposed revolutionary change in our own country. The stage was set, and the expectation of rapid accomplishment was early evident on the part of the politician. Failure of the medical profession to accede to regimentation and to acknowledge government control spelled the doom of the social planners' schemes and relegated some of the most ardent supporters to the sidelines.

One could not, however, deny the fact that people had a right to medical and hospital care. The very nature of the profession of medicine made it imperative that such a philosophy be recognized, and the respect of that profession for the dignity of the individual made it necessary to preserve and protect that dignity wherever possible. There is certainly universal belief that the best way to protect the dignity of the individual is to make him self sufficient economically so that he may freely provide for himself

President, Massachusetts, Medical Service.

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and his family. No free man likes a handout, whether it be food, money or medical care.

During this period of time the Social Security system was established and various attempts to provide employment or furnish economic aid for the individual came into being. These were the days of the P.W.A. and the W.P.A. Food was doled out to the needy. It was obvious the government was attempting to meet its conceived idea that it was responsible for the general public welfare. Heavy taxation by the federal government became the accepted pattern. This in turn required increased numbers of federal employees to administer the new role of that agency in our lives.

### **Medical Profession Responds**

Criticism of the medical profession for its do-nothing attitude grew to the point where the profession was on the defensive much of the time. One cannot long maintain an attitude of uncompromising opposition without jeopardizing his position in the controversy and consequently losing support for his point of view, and this is especially true where the general health of the public is concerned and where the question of the cost and availability of good medical care is the weapon of the politician and social planner. It became evident that some mechanism for the economic solution of the dilemma must be developed by or on behalf of the medical profession.

In certain areas the insurance industry was approached to develop a program of insurance to meet the problem, but turned the request down as an unfeasible approach from an insurance standpoint. This refusal further complicated the situation, for who would have the temerity to undertake a program considered unworkable by those with the greatest experience? Would this again turn out to be a case of where fools rush in where wise men fear to tread? There was one redeeming feature, however, and that was that the profession was of paramount importance in any program for the delivery of medical care to the public. The fundamental root of the problem was that still little understood commodity known as money. Could good medical care be made available to the public at a reasonable price to the bulk of the people, and how could the financing be arranged in a manner suitable to both the public and the profession with the maximum conservation of the funds for the essential purpose of the mechanism devised?

There had been in operation in some medical societies postpayment committees through which provision was made between a patient, the physician and a bank for payment after the fact to a physician for services rendered, and the bank received payment in installments from the patient much as an automobile is paid for after delivery. It seemed possible to reverse this procedure and establish a pay-away plan where monies were paid in advance for potential future services. This plan envisaged the old pattern of providing for one's future goods or services in advance of the event and certainly would tend to preserve the independence and dignity of the individual. Such a program developed and controlled by the profession appeared to be more economical and sound than any government program. Would the public support such an undertaking and how much would it pay for an intangible situation of potential illness which might not occur for months or years?

The financial value of the many man hours spent by concerned individuals in the early planning of the solution was tremendous. Cautious beginnings were made and limited plans developed in an attempt to guarantee the solvency of a plan and to gain information about utilization and to develop actuarial knowledge regarding the adequacy of the premium for the items already insured and those contemplated.

The social theorists were insisting that the medical profession could not do this job without the help of the government while at the same time the insurance industry said the problem could not be solved by insurance methods. Doubting Thomases were not conspicuous by their absence.

How well has the profession succeeded in its attempt to meet the greatest economic challenge of its existence? In spite of all the skepticism, Blue Shield represents the biggest development in medical economics ever voluntarily undertaken and successfully executed by the medical profession. Blue Shield did not just happen. It was planned, organized and dedicated to serving the health needs of the community. Just as physicians serve rich and poor alike, so Blue Shield seeks to enroll people of every class and condition, not just those select groups who offer the best prospects of profitable underwriting. Blue Shield is not just another insurance company. It is a direct agency of the physician himself, guided by the profession and not operated for profit. It was created by medicine to do what the physicians of our profession traditionally have always sought

to do, to meet the needs of the entire community. The tremendous growth of enrollment has been one of the fantastic developments of our time. I shall not concern you with the results of all agencies operating in this field. It must be borne in mind that once the medical profession was able to demonstrate the feasibility of this approach to the economics of medical care, the insurance industry undertook similar programs and has done a phenomenal job of helping to cover the public for this type of protection. Indirectly, the medical profession deserves credit for leading the way in developing methods for such coverage and was therefore instrumental in making such programs available by the insurance industry.

I believe the profession feels a most satisfactory and phenomenal result has been obtained from the standpoint of the number of people now included in Blue Shield. From none to over 42 million people in the space of two decades is no mean feat of accomplishment. Associated with the growth in numbers of individuals covered there has been a concomitant improvement in the scope and character of benefits included and offered. In-hospital medical care, prolonged and major illness contracts, improved service limits and increased fees, and surgical and x-ray coverage outside the hospital are but a few of the refinements which have taken place as the numbers covered by this protection have grown. Payments to physicians by Blue Shield alone now amount to over 400 million dollars a year. Prepayment plans now pay almost 35 per cent of all doctors' fees. It must be borne in mind that premiums represent monies which belong to the public and which have been contributed for a specific purpose. The responsibility for their conservation and proper expenditure is a sacred trust given into the hands of those directors responsible for their proper expenditure is a sacred trust given into directors and upon the medical profession itself a tremendous obligation to see that those funds are not dissipated in whole or in part by the actions of unscrupulous physicians who visualize this pool of money as an easy source of income to be appropriated by the use of improper or actual false claims for services rendered.

#### **Future Outlook**

What of the future? Can we stand still and merely be satisfied with our accomplishments to date? Shall we continue our progress toward more and better protection for the public? Unless there is improvement and continued success, the specter

of failure becomes a fearsome reality. One can no more stand still in this venture than one can close the door to future clinical and laboratory advancement in the art and science of medicine. If anyone for the moment thinks this is not a fundamental problem for the future of prepayment, he must be as an ostrich with his head in the sand. The events since the November election should make one wary of even entertaining the thought of smug satisfaction.

Some people say we have two classes of people in Washington government, elected public officials and politicians. The term elected public official is reserved for those who are believed to have a genuine interest in the welfare of the people whereas the politician is the one who is concerned primarily with his own political future, which must be enhanced by publicity aimed at the masses for whom he claims to have unusual interest, particularly of a humanitarian nature. The claim that he is more interested in the poor sick individual than the physician or anyone else is his stock and trade. He knows this has appeal to the average person much more than has the Tennessee Valley Authority or the St. Lawrence Seaway. It is much more likely to get him headlines because the financial aspects of health and illness are important to every individual. It is difficult for the medical profession to combat such a person because there is little defense value in saying you are sorry about the unfortunate case which can always be produced to illustrate the imperative need for government to assume responsibility for the medical care of the general public. In spite of the record, the politician says that prepayment plans have failed to do the job, that the coverage is inadequate, that there are too many exclusions, and that people cannot obtain protection because of age, conditions of employment, or inadequate economic status.

With this specter of the politician pushing the profession to the brink of disastrous change, can there be any question as to what your future goal must be? Every avenue of improvement consistent with good medical care for the public with adequate protection for the profession must be explored. Extension into the field of long term illness and the inclusion of coverage for the individual and old age groups must be sought and developed. The problem of a fully or partially paid up plan prior to retirement must be explored with other insurers who may cover the risk at various times during the working period of the individual and which would necessitate the pool-



ing of the excess premiums paid to the various carriers.

When the Wagner-Dingell-Murray Bill went down to defeat, there were many who said socialized medicine was a dead issue. I should like to warn you that the danger is greater today than at the time of the original onslaught by the famous socializing trio. There are obvious reasons why this is true. In the first place the cost of hospitalization has risen to an alarming degree. Even with Blue Cross coverage it is not unusual for a person to have to pay \$15 to \$20 a day when his Blue Cross allowance is only \$7 per day. One month's illness can bankrupt a retired person, or make it necessary to mortgage his home or sell the convenient old car. It has been estimated the cost of hospitalization will increase 5 per cent a year in the foreseeable future. This rise means increased Blue Cross and insurance rates. In a number of states, requests for increased rates have led to investigations by legislative or insurance regulatory bodies. The hospital problem may be the Achilles heel of prepayment medical care plans. The constant irritation to the public by increased hospital costs and increased hospitalization insurance premiums affords a fertile field for the politician's harangue.

A second factor which makes for increased danger of governmental interference is the fact that Social Security is well established and widely accepted, even to the point where physicians want to be included. While nobody likes taxes, nobody does much about them. Once a tax is established, it appears relatively easy to increase that tax. One of the best examples is the little reaction to adding another cent to the gasoline tax. Nobody thinks much about it, and yet in some states the gasoline tax is equivalent to more than one third the cost of the gasoline. I think everyone will agree that a 33 1/3 per cent tax is a pretty substantial tax.

How much opposition do you think there would be to adding another 1 per cent to the employee's Social Security tax? Probably not much, if any, if the employee knew he was going to get additional benefits for which he is to pay only half the premium. This addition to the Social Security tax is much easier to accomplish today than it was to propose a tax for socialization of medicine at the time of the original Wagner-Dingell-Murray bill. Recently Mr. Dingell introduced his bill which he says is similar to his father's original bill. In a radio interview he stated this would be financed by a 1.5 per cent

tax on the employer and employee. It may be that we have here in the making a peculiarly ironic situation, physicians asking to be included under Social Security and ultimately being taxed to support a program of governmental medicine which would destroy the freedom and private practice of medicine.

It is a matter of serious concern to many people that the matter of hospitalization as a private enterprise may in the not too distant future succumb to the inevitability of government support. You are all familiar with the Canadian government hospitalization program. It appears much more than a remote possibility that the same thing may happen here. I seriously doubt that the average person will strenuously object to an increase of 0.5 to 1.5 per cent in his Social Security tax to pay for hospitalization if and when he or his family is in need of such care. I am not convinced that some hospital administrators care much about whether the dollar comes from private enterprise or from government as long as the dollar is forthcoming. Whether the medical profession can remain a free agent in its dealings with the public once hospitalization is provided by the government is a frightening but pertinent question. At least it can be said that our position will be much more vulnerable once that occurs, and it is not entirely conjecture to visualize demands or at least accession to the opportunity to add the remaining factor of medical care to the package.

Mr. Forand of Rhode Island is back with his bill and is determined to make for himself a niche in that monument to those suffering for the neglected public. In New England we had never heard of Mr. Forand before, and so you can see how effective it is for a congressman to espouse the cause of government interference in the practice of medicine. I have often wondered why some of the people who bleed so for the poor sick public did not study medicine where they could really be of service to mankind, where they could spend all night with a poor sick patient with no thought of compensation, or where they could get actual and not vicarious satisfaction from buying out of their own pockets the liver extract for the mother with pernicious anemia or the bread and milk for the malnourished child. This represents true human compassion but it does not get your name in the headlines. It is so easy to recommend the appropriation and expenditure of somebody else's tax money and it is similarly so easy to tax the bulk of the people into economic subservience to a paternalistic government with



the consequent destruction of their freedom by such dependence.

It has been said that the man of the future will be as free as his fellow citizens let him be. In earlier times, when the population was sparse, a man, or at most his family, did most everything for himself. Now you and I can do little for ourselves. We do things for each other. This situation arises partly out of increasing specialization and partly out of the pure fact that there are more of us living closer together. A man's freedom in the future will be measured by the willingness of his neighbors to give him what he wants.

### Men of Vision

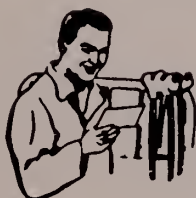
Industry today believes the quality of vision is the one in greatest demand for its executives. Thank God, we have in Blue Shield today many men of vision who gaze into the future and assess the pathway which we should take for continued success in our attempt to provide prepayment medical care for the public which has been so generous in its cooperation with the medical profession in paying the price for the programs offered. Your own Mr. Schroder and Dr. Carson are well recognized as having that quality of vision necessary to our continued future success. The least you and I, as practicing physicians, can do is to offer our cooperation to such individuals in the matter of research and understanding of common goals for the better protection of the public and the preservation of our freedom.

I believe we have come close to the point where the freedom of any individual doctor must

be weighed against the freedom of the profession as a whole. In the face of tremendous odds, can we hold to the belief that a physician is entitled to whatever the traffic will bear?

One might well ask if we have come to the time when we should arrive at a fair price for our services in order better to guarantee the stability of a prepayment plan and thus prevent the overcharging by a minority which subjects the entire profession to the greatest criticism at the present time. It looks as though time is getting shorter and that we need all the dependable ammunition we can obtain to hold the line against increasingly serious threats to our freedom. The challenge is great, but I have no doubt we can again meet it with increasing vigor and reliable facts. It is going to take a great deal of cooperation and understanding among us to accomplish this feat in the face of tremendous odds. I would call upon you to give to this matter the same degree of serious consideration and study you would give to a medical problem in order that we may come to some common understanding of our future goal and the methods by which we can reach that objective. You and I have a most serious obligation, not only to the public which has cooperated so wonderfully to make prepayment the outstanding success which it is today, but also to those young men and women who desire to enter the practice of medicine and for whom we must strive to preserve the freedom of that profession as you and I have known it.

38 Chauncy Street, 6.



## ABSTRACTS

### **Pulmonary Aspergillosis: A CASE REPORT.**

By J. H. Smith Foushee, M.D., and Franklin G. Norris, M.D. *J. Thoracic Surg.* 35:542-548 (April) 1958.

Aspergillosis may affect the lung as a primary infection, or may be secondary to tuberculosis, bronchiectasis, or other chronic diseases of the lung. Primary pulmonary aspergillosis, however, is not a common clinical entity, and only recently was pulmonary resection undertaken for this lesion. The case here reported represents a patient with primary pulmonary aspergillosis who underwent surgical resection of the involved lobe of the lung, with apparent cure of the disease. This is the eighth case of localized primary pulmonary aspergillosis treated by lobectomy reported in the United States to date. The clinical, roentgenographic and pathologic findings and the treatment in this case are discussed, and the authors suggest that this disease should be considered in any patient with localized or diffuse pulmonary lesions with or without symptoms.

**Certain Aspects of the Practice of Medicine Among Females of Primitive and Modern Societies.** By Joseph L. Selden, Jr., M.D. *South. M. J.* 51:1438-1443 (Nov.) 1958.

The author contrasts, in a philosophical vein, the gynecologic problems encountered in a primitive society with those of his present practice among women of today's highly civilized society. During three of seven years spent in the tropics, he had charge of a 35 bed Mission Hospital in the Liberian Hinterland in West Africa, serving primitive people whose culture had not advanced much beyond that of the iron age. Most of them were animists or spirit worshippers. The volume of work in obstetrics and gynecology was limited to the semicivilized and those who were in extremis because of the Moslem ban and the bush taboo on men attending women in these departments, but the native customs and practices were studied. During his entire stay he did not treat a patient having gastric ulcer, hypertension, asthma, allergy or dysmenorrhea, and there was only one case of appendicitis in a semicivilized man from the coast. Yet every patient had some definite pathologic condition; all had either a blood stream, urinary or intestinal parasite, or perhaps

all three. If psychosomatic conditions existed among these people, they were never apparent in the hospital. The emotional problems that existed were channeled through outlets other than somatic.

Treating the gross and definite pathologic entities of these people was in sharp contrast to treating the modern woman of the atomic age with her frustrations, tensions and feelings of insecurity, all obscured by suppression and repression. This disconcerting experience led Dr. Seldon to appreciate particularly the inseparable relationship between psychiatry and gynecology since gynecologic disorders are often symptoms of an illness of living. He concludes that many women respond better to ventilation than to operation.

**The Prevention of Cardiac Arrest in Ocular Surgery.** By Ralph E. Kirsch, M.D. *South. M. J.* 51:1448-1453 (Nov.) 1958.

Estimating that cardiac arrest occurs once in approximately 3,500 eye operations, the author presents interesting studies to clarify the occurrence of cardiac arrhythmias which may accompany manipulation of the eyeball or its parts, and suggests prophylactic measures for the prevention of these effects. He points out that the major causes of cardiac arrest during ocular surgery are fear, hypoxia, hypercapnia, sensitivity to and overdose of drugs, and nervous system reflex changes, and he recommends measures to deal with the first four causes. Concerning the reflex changes, the cardiac effect of many ocular surgical maneuvers has been investigated in the operating room by means of serial electrocardiography. In the 50 cases studied, significant electrocardiographic changes were induced by ocular stimulation in 15 cases, or 30 per cent. These changes were the appearance of nodal rhythm, marked bradycardia, and in two cases temporary cardiac arrest.

The ocular stimuli found to produce these changes were digital pressure upon the globe, manipulation of the extraocular muscles, and direct pressure upon the tissue remaining in the orbital apex after enucleation. The changes occurred under either local or general anesthesia. Evidence has been adduced which indicates that ocular stimuli are more provocative of these electrocardiographic changes than are stimuli in

the respiratory tract; that is, the oculocardiac reflex is more sensitive than the pulmonocardiac reflex. Complete abolition of these electrocardiographic changes induced by ocular surgery was accomplished in every instance by the retrobulbar injection of an anesthetic. It is therefore recommended that a retrobulbar injection of an anesthetic be made a routine safeguarding procedure in every operation for strabismus, retinal detachment, and enucleation of the eyeball.

**Chlorothiazide (Diuril) as a Hyperuricemic Agent.** By Benjamin G. Oren, M.D., Maurice Rich, M.D., and Martin S. Belle, M.D. J. A. M. A. 168:2128-2129 (Dec. 20) 1958.

Chlorothiazide (Diuril) has been recently introduced into therapeutics, first, as an effective nonmercurial diuretic and, more recently, as a potentiating hypotensive agent in the treatment of essential hypertension. The purpose of this preliminary communication is merely to direct attention again to the prevalence of hyperuricacidemia with its use and also to indicate that goutlike symptoms may occur in certain patients. Recently, the authors noted that some patients, during the use of this drug, experienced joint pains, especially in the feet. Investigations established no organic cause for this symptom, but the uric acid levels in the blood were found to be elevated. Of 12 patients studied with significant elevation of blood uric acid levels, ranging from 6.3 to 10 mg. per hundred cubic centimeters, only three experienced joint pains in the feet, and in only one patient was there positive roentgenographic evidence. It is concluded that patients who have a history of gout should be watched with especial care, and it is expected that further study may clarify the mechanism of this side effect of this valuable agent.

**Wounds of the Rectum.** By C. Frank Chunn, M.D., F.A.C.S. S. Clin. North America 38:1649-1659 (Dec.) 1958.

Injury to the anorectal tract doubtless has always been more common than the literature on this subject indicates. The purpose of this presentation is to offer a practical guide to surgical therapy of this segment of the gastrointestinal tract which reflects the lessons learned from war surgery.

The management of wounds of the anorectal tract is a problem encountered with relative in-

frequency in civilian practice. The serious nature of such accidents, however, is attested by the high mortality in reported series, ranging from 20 to 50 per cent. Immediate recognition of the lesion and prompt appropriate treatment are of the greatest importance in the prevention of serious complications and possible death.

The principles and practices of anorectal surgery established in World War II and their role in greatly reducing mortality are reviewed. The subsequent application of these principles in civilian practice with gratifying results is discussed, and a guiding outline is presented.

**Heart Size in Adolescents.** By John M. Packard, M.D., F.A.C.C., Leo A. Strutner, Jr., M.D., Richard S. Melton, Ph.D., and Irving P. Ackerman, M.D. Am. J. Cardiol. 1:170-178 (Aug.) 1958.

This report is based on a cardiovascular survey of 2,600 school children in Pensacola, carried out jointly by the Florida State Board of Health and the U. S. Naval School of Aviation Medicine. Measurements of heart size were made from the teleoroentgenograms of 2,138 healthy school children 12 through 17 years of age. There were 1,072 boys and 1,066 girls studied, none of whom had clinical or electrocardiographic evidence of heart disease. Results of extensive statistical studies were: (a) Age, sex, and body weight were the most important variables in determining heart size in these adolescents; (b) body height and certain chest measurements did not correlate highly with heart size; (c) transverse diameter of the heart was less variable and therefore in some ways a more preferable measurement than either frontal area or cardiothoracic ratio; and (d) none of the presently available tables, formulas, or nomograms for predicting the transverse diameter or the frontal area is adequate for adolescents because none of them uses age or sex as variables.

Tables for predicting the transverse diameter and frontal area of the heart in adolescents using age, sex, and weight as the variables are presented. Use of these variables should result in better predictions than those obtained by other presently available methods.

**Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.**



## Our Turn

The 108th Annual Meeting of the American Medical Association in Atlantic City in June was no ordinary affair. I regret that more of our own members from Florida could not be present to share in the special pride that was Florida's at this meeting. The last registration count published by the A.M.A. Daily Bulletin was 12,921 physicians registered and a grand total, including guests, of 28,225 persons present. There were 147 members of the Florida Medical Association registered.

Every member of the medical profession everywhere has a right to be proud of how our profession was represented by our own Dr. Louis M. Orr when he was inaugurated as the 113th President of the A.M.A. Medicine was honored by the appearance of President Dwight D. Eisenhower, who became the first President of the United States to address an A.M.A. meeting. Further dignity and honor came to Medicine with the address of Doctor Orr. It was a special privilege to be present, and it gave one a feeling that he was seeing and hearing the leaders of the greatest nation in the world and the greatest profession in that nation.

Florida physicians also have additional rights to pride. The "Supreme Court" of the A.M.A., The Judicial Council, is still headed by Chairman Homer L. Pearson Jr., of Miami. Your Delegate, Reuben B. Chrisman Jr., of Coral Gables, is still a member of the Council on Medical Service. Your other members of the House of Delegates, Francis T. Holland of Tallahassee, Meredith Mallory of Orlando and Burns A. Dobbins of Fort Lauderdale, were very busy looking out for your welfare as American Medicine conducted its business.

Yes, Doctors, we sent a truly outstanding delegation to represent us and they have done exceptionally well, but now it is our turn to go to work. The 108th Annual Meeting of the A.M.A. in Atlantic City is history. All eyes are now on Florida. Our "favorite son" is now President of the A.M.A. The 109th Annual Meeting will be on Florida soil at Miami Beach. These facts just did not happen that way. They are the result of well directed effort on the part of that few of us, but to be successful, it requires the combined efforts of all of us. Let us see that we reflect the Florida sun brightly by a constant, solid support of our President Louis M. Orr. Let us make the 109th Annual Meeting at Miami Beach a ray of sunshine in A.M.A. history —never-to-be-forgotten.

A handwritten signature in dark ink, appearing to read "Reuben B. Chrisman Jr.", written in a cursive style.

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# The Third Greatest Cause of Death

The changing causes of death reflect the rapid advances made by medicine with the help of other scientific disciplines and of engineering. The dramatic reduction in deaths from infectious diseases, disorders of nutrition, and complications of childbirth should make physicians proud. The great strides made in the attack on fatal illnesses have understandably caused physicians to give less attention to those illnesses which cause disability without death. The amount of personal suffering and economic loss from disability may be very great, however, as is well illustrated by such diseases as the common cold and arthritis, and by accidents. The effectiveness of the research approach to control of illness, once the problem is defined, has been amply demonstrated many times in the past. In order to pinpoint areas which would be fruitful for further attack, we must have adequate records not only of deaths but of disabilities.

The relative rise in accidents as a cause of death and disability reflects the increasing mechanization of our civilization. In the past, farms have been a major site of accidents. The character

of the injuries is changing as the farm becomes no longer a single family enterprise but one of collectivization of small units into "big business," frequently a corporation which increasingly uses many types of farm machinery. Industry has been familiar with the problem of accidents for years. Recognition of the types of injuries has led to solution of the engineering problems involved through the design of protective devices around moving parts. As the problem of protection from moving parts is solved, more attention should be given to the use of color to make potentially dangerous areas more visible and relieve monotony. The control of noise will reduce fatigue and the hypnotic effect which frequently lead to an increased incidence of accidents.

As physicians see accidents in the office and the hospital, they should make detailed records so that patterns peculiar to Florida or to various parts of the state can be recognized and identified. More and more it is being recognized that the human factor is perhaps even more important than the mechanical one. The monotony of a repetitive job, the lack of a feeling of importance

on the part of the worker and the failure to feel a sense of personal achievement in a job may well set the stage for an accident. The physician is in the best position to recognize neurologic or other organic disease which would make the patient susceptible to accidents. He is also in the best position to recognize emotional factors which may pave the way for accidents. Patients turn to alcohol and sedative drugs in a retreat from family or other tensions, but in so doing they interfere with judgment and physiologic response to potential danger.

Accidents have now become the third greatest cause of death. They are exceeded only by cardiovascular diseases and cancer in all age groups. Accidents, however, are particularly important since the highest proportion occurs in the productive years of life when the earning capacity of the individual is at a peak. It has been estimated that 106,000,000 working days per year are lost from accidents. Over the years and regardless of age, it has been true that males have accidents more frequently than do females. Whether this reflects a greater natural aggressiveness of men seeking to demonstrate their masculinity, or whether it is another example of the increased fragility of the male is a matter for speculation. In any event, the so-called weaker of the sexes does not sustain more accidents than the stronger until age 65 or older. It is a tragedy that in automobile accidents, which account by far for the greatest number of deaths, an appreciable percentage involves no other car. A surprisingly high proportion of deaths occurs when a pedestrian is struck. It is interesting that at intersections it appears to make little difference whether the pedestrian is crossing with or against the traffic lights; the greater proportion of the accidents occur in the middle of the block or on roads where there is no intersection. The great majority of collisions occur in clear weather on dry roads between 4 and 8 p.m. on Friday, Saturday, and Sunday. It can hardly be overemphasized that automobile accidents are the greatest cause of death and disability in the Armed Forces during peace time. One can only conclude that human factors are to blame.

Though automobiles account for by far the greatest number of deaths, accidents in the home, particularly falls and poisonings, account for a very high percentage of disabilities. Roughly 40 per cent of all accidents in which activity is restricted fall within this category. Home accidents are a matter of concern for the entire family.

The magnitude of the problem of accidents in Florida has been difficult to determine. Figures collected by the State Board of Health for the Governor's Committee on Indigent Medical Care show that during the week of May 1-7, 1958, 727 persons were hospitalized in Florida as a result of accidents of all types. This number represented 8.6 per cent of all patients in acute hospitals that week. No information is available on the number of those who sustained accidents, were treated by physicians, but did not require hospitalization. In Florida in recent years, a steady rise has been noted in deaths due to drowning and accidents involving small boats. These deaths reflect increased use of our recreational facilities, but also point up areas in which a concerted attack from many points of view might be profitably made. In Florida the figures show that between ages 5 and 24 accidents are the *greatest* cause of death.

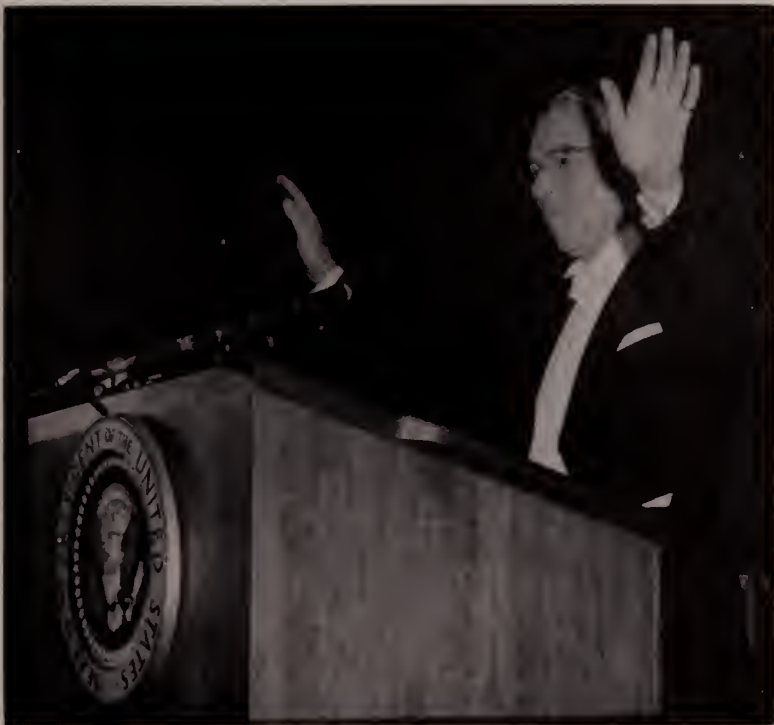
Most accidents are preventable. As was pointed out in the Symposium on Accidents presented on the scientific program at the recent meeting of the Florida Medical Association, many accidents can be anticipated; the situation leading up to them develops sufficiently slowly that preventive measures can be instituted. The problem is how to identify the situations which result in preventable accidents. The Symposium indicated that we should periodically examine the legal situation to see that present laws are being enforced and to identify areas which require new legislation. As was pointed out in the Symposium, the role of the private practicing physician in the prevention of accidents is a key one. The experience of industry in the reduction of accidents has indicated that the most effective approach is not the one of posters, lectures, and mass education, but of hammering home on an individual basis the measures to prevent a recurrence as soon as the accident has occurred. The physician is in an ideal spot to educate the patient and his family in the cause and prevention of accidents while he is treating the unfortunate victim of one. Physicians can be very effective if they will make a concerted continued effort to approach this problem on the broadest possible front in their home communities.

**Eighty-Sixth Annual Meeting  
Florida Medical Association  
April 8-11, 1960  
Jacksonville**



## Inauguration of Dr. Louis M. Orr As A.M.A. President

Dr. Orr, prior to presenting his address "This We Believe," acknowledges the ovation of more than 5,000 persons assembled to witness ceremonies which made him the 113th president of the American Medical Association.



Florida Medicine's proud moment came on June 9, 1959, when Dr. Louis M. Orr of Orlando became the 113th president of the American Medical Association. Dr. Orr is the first member of the Florida Medical Association ever to attain this distinction. The inaugural ceremony took place in the ballroom of the Convention Hall in Atlantic City, N. J., as part of the 108th Annual Meeting of the American Medical Association.

Following the farewell address of Dr. Gunnar Gundersen of La Crosse, Wis., the outgoing president, Dr. Orr was installed as the new president by Dr. Leonard Larson of Bismarck, N. D., chairman of the Board of Trustees.

The featured guest and special speaker at the inauguration was President Dwight D. Eisenhower. His appearance marked the first time a President of the United States had addressed an



The oath of office of president is administered to Dr. Orr.



Dr. Orr congratulates Dr. Michael E. De Bakey of Houston, Texas, who was presented one of medicine's highest awards, the A.M.A.'s Distinguished Service Medal. The ceremony was one of the highlights of the evening devoted to inauguration events.

A.M.A. annual or clinical meeting. Excerpts of his speech are published elsewhere in this issue of *The Journal*.

A practicing physician since 1927, Dr. Orr has spent his entire professional career in Orlando. For more than a decade he has won distinction as an extremely able representative of the Florida Medical Association in the House of Delegates of the American Medical Association. His many activities in the parent organization include service as vice speaker of the House of Delegates, as chairman of the federal medical services committee, as an ex officio member of the Council on Constitution and By-laws, and as a member of the Council on Medical Service. Elevation to American Medicine's highest post comes as a well deserved honor.

In his inaugural address, entitled "This We Believe," Dr. Orr stressed his belief in certain fundamental ideas pertaining to medicine, democracy and faith which are vital to medicine, to America and to mankind. A staunch champion of physicians as citizens who believe in individual



Dr. Gunderson, President Eisenhower and Dr. Orr listen to the 66 member chorus from Fort Dix, one of the many colorful features at the inaugural ceremony. The addresses of Dr. Orr and President Eisenhower appeared later on the program of the evening.

freedom, individual rights and individual responsibilities, this eminent Florida urologist said:

"We believe that the basic element of progress is not compulsion but voluntary cooperation; not force but reason; not blind obedience but independent intelligence; not timidity but faith—faith in man, faith in ourselves, faith in God.

"We believe that freedom, to survive and grow, can never be placed upon a shelf and forgotten, but must be fought for again and again, day after day, by men and women willing to stand up and be counted. We reject any philosophy alien to these beliefs."

While the medical profession must continue to furnish the best possible health care to every American, Dr. Orr particularly emphasized the importance of caring for the older citizen. He urged the profession to continue to improve and broaden voluntary health programs in preference to compulsory programs that lead to waste, and

to continue to defend the unfettered, inquiring mind, for medical progress depends upon the relentless quest for truth by minds that are free.

Defining the practice of medicine as "more—much more—than merely facts and experience," Dr. Orr continued: "It is new knowledge, new ideas; a blending of the best of the old with the best of the new. It is the 'invincible belief' of Louis Pasteur that 'science will triumph over ignorance, that the future will belong to those who have done the most for suffering humanity.'"

Observing that physicians who watch over men, women and children in their darkest hours know that inside every man there is an unquenchable spirit linked to life and love, mercy and hope and the eternal values that come from the Creator, Dr. Orr reiterated his conviction in closing that "upon this knowledge is built our firm belief—the belief that the fundamental obligation of our profession is to maintain medicine's role as the faithful servant of mankind."

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## President Eisenhower Cites Threats to Freedom At A.M.A. Inaugural Ceremony

Making an unprecedented appearance before an overflow crowd at the presidential inauguration ceremony of the 108th Annual Meeting of the American Medical Association in Atlantic City in June, President Eisenhower ruled out state-aided medicine and asked the support of the medical profession in his effort to balance the federal budget. He told the assembled doctors that "the medical profession, as much as any other, has a vital role in preventing inflation" and that "certainly it wants to provide its services for a fee within range of what people can reasonably pay." Then he added:

"If the time ever comes when large numbers of our citizens turn primarily to the government for assistance in what ought to remain a private arrangement between doctor and patient, then we shall all have suffered a great loss.

"The cost of inflation is not paid in dollars alone, but in increasingly stagnated progress, lost opportunities, and eventually, if unchecked, in lost freedoms for the doctor and patient."

Drawing a parallel between bodily and economic health, the President cited a balanced diet:

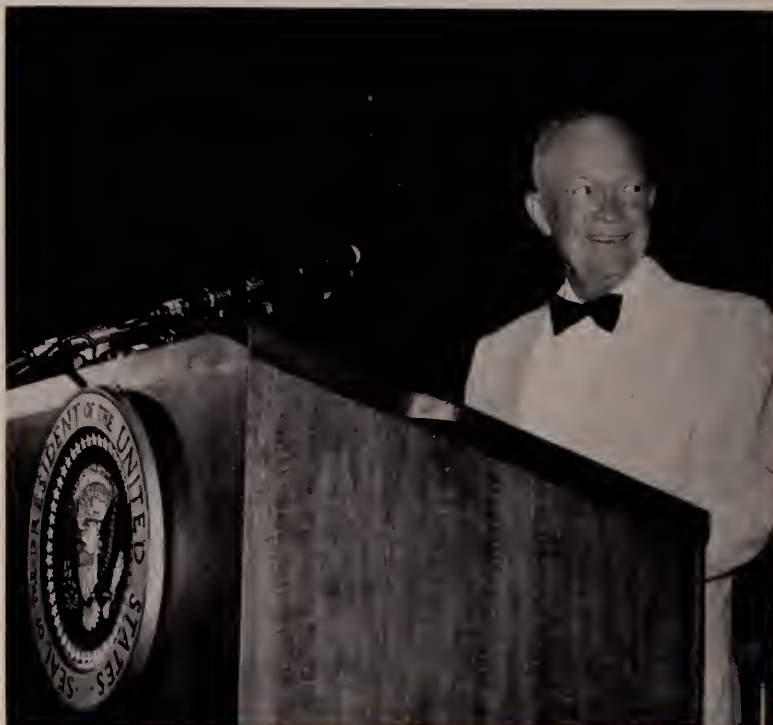
"In this sense the relationships between the balanced diet and balanced budget are easily understood. Neither is an end in itself. There are some useless items of food all of us crave and do eat, no matter how unwisely, just as there are always products and services for which we thoughtlessly spend, often to our own detriment. But in each instance we must conduct ourselves with a wary eye on the consequences. Habitual violation of the requirements of a balanced diet can lead to ruined health; deliberately to unbalance the Federal budget in time of huge indebtedness and rapidly increasing prosperity can bring about an enfeebled economy. The choice, therefore, is ours, and we must act with clear mind and resolution in either case.

"In the management of our governmental activity one simple need is for judgment, frugality, and restraint."

Continuing in the anti-inflationary context, he said: "For those who will take the trouble to look there is no difficulty in seeing the relationship between fiscal responsibility and a successful, meaningful life for all in a climate of freedom. I



President Eisenhower delivers his address "The Doctor's Influence on Civilization" at the 108th annual meeting of the American Medical Association. He is the first President to attend an annual or clinical meeting, however, in 1953 he addressed a special session of the House of Delegates held in Washington, D. C.



President Eisenhower is met immediately after leaving his plane, the Columbine, by Dr. Leonard W. Larson, chairman of the A.M.A. Board of Trustees, Dr. Orr and Dr. Gundersen. (left to right)



Dr. Orr, President Eisenhower and Dr. Gundersen pause during inauguration ceremonies for the benefit of approximately 300 representatives of newspapers, television and radio stations in Atlantic City for the A.M.A. annual meeting.

am confident that you doctors, as community leaders in great urban centers and in the villages and farm areas of America, can do much to promote greater understanding of the importance of this vital relationship.

"So I believe that, as you show us how better to preserve our own health, you can do a great service to yourselves, and to all of us, as you teach that the future of our Republic and the free world depends upon our ability to maintain fiscal soundness in government, a robust economy, and a stable dollar."

Mr. Eisenhower expressed particular concern over unchecked inflation as it affects older people who live largely today on fixed retirement incomes as represented by pensions, insurance policies and savings. "To this group, inflation is not merely a threat—it is a robber and a thief," he said. "It takes the bread out of their mouths, the clothes off their backs, and it limits their access to the medical care and facilities they need.

"Here is a situation that calls for true team effort among the medical profession, industry, government, and the broad body of our citizenry. We must work together to make possible for our senior citizens, meaningful activity so that they can become—as they all hope to—independent, useful and creative members of our society."

He praised the American Medical Association for its leadership in helping to meet the needs of the rapidly expanding old age population in these words: "I learn that the American Medical Association has embarked upon an all-inclusive program to re-orient our thinking about the place of elder citizens in modern society and to help them meet their health care needs. I am indeed gratified to know of this program. In health as elsewhere in American life, our summons to greatness calls for a lively partnership of individual effort, with action by voluntary agencies and private enterprise and, where necessary, government action at appropriate levels."

The President stressed the medical profession's responsibility to make a "dynamic response" in "an age of ceaseless challenge." Declaring that accelerated progress must lead to the mastery not only of the newer threats to human health and vigor but also to such age-old diseases as cancer, diseases of the heart and mind, and disorders of the central nervous system, he reminded his physician-audience that they must "not forget the common cold." "Medicine provides one field in which all humankind can unite against a common enemy—disease," he said. "And beyond and above this battle, we must still tirelessly work to overcome the most menacing of all our maladies, the

social sickness of war and the untold suffering it brings upon us."

The President concluded: "Members of the medical profession, peace and ennoblement of the human spirit are the common aims of free societies. True to our country, to the cause of freedom and to our God, we shall pursue these aims, without ceasing or tiring. So doing, we shall one day establish a durable world community of peace-loving nations in which suffering born of strife will be known no more. In bringing about this happy result no one can or will do more than the doctors of medicine."

As the speaker of the evening the President followed Dr. Louis M. Ori of Orlando, the newly inaugurated president of the American Medical Association, who presented his inaugural address.

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### **Boynton Beach Hospital A Community Project**

Admission of the first patients to Bethesda Memorial Hospital, Boynton Beach, on February 9 of this year culminated a 10 year effort to obtain a hospital to serve the 36,000 residents in southeast Palm Beach County. The new 80 bed facility, located on a 13 acre-site, was built, equipped, furnished and landscaped at a cost of \$1,200,000 derived from tax revenue and thousands of dollars in gifts from area residents and winter visitors. Tax funds were made available for construction and operation of the hospital when the Southeastern Palm Beach County Hospital District was created by referendum vote in November 1955.

Communities within the hospital district are Delray Beach, Boynton Beach, Boca Raton, Gulfstream, Ocean Ridge, Highland Beach and Village of Golf. The district is governed by a seven member board of commissioners who are appointed by the governor of Florida from nominations made to him by the Bethesda Hospital Association, "parent" organization of Bethesda Memorial Hospital.

Dr. Merrill F. Steele, formerly superintendent of the 450 bed Christ Hospital, Cincinnati, Ohio, is the administrator. A pioneer in hospital administration, Dr. Steele was graduated cum laude from the Indiana University School of Medicine and began his medical career in the field of roentgenology. The Bethesda administrator was a founder of the American College of Hospital Administrators, one of its charter fellows and a past president of the organization. He has also been a

vice president of the American Hospital Association and a member of various commissions, studying such subjects as chronic diseases, crippled children, epileptics, the mentally ill and the feeble-minded.

Dr. Graham W. King, Jr., a past president of the Palm Beach County Medical Society and practicing physician in Delray Beach for a quarter of a century, was unanimously elected Chief of the Medical Staff, which numbers 21 active members, including two dentists, 19 courtesy members and one privilege staff member. The staff is augmented by 54 visiting consultants who, with the exception of five district dentists, are doctors and dentists from Broward County or outside the district in Palm Beach County, so that the hospital district residents have the most comprehensive medical treatment available to them.

Three hundred seventy-nine patients were admitted to Bethesda Memorial Hospital, representing 2,028 hospital days, during the first two months of operation. The admissions total for February was tripled in March. For the same period of time, 765 x-ray examinations were made, which figure includes outpatients and hospital employees.

The complete facilities in the x-ray, laboratory and pathology departments represent the most recently developed equipment available. The hospital has two major surgeries, an emergency surgery, two delivery rooms and two nurseries. In line with present day thinking on hospital planning, there are no ward facilities in Bethesda Memorial Hospital. Patient accommodations are private and semiprivate.

Doctors and hospital administrators who have inspected Bethesda Memorial Hospital term it one of the outstanding small hospitals in Florida.



Front Entrance of Bethesda Memorial Hospital, Boynton Beach, new 80 bed hospital opened February 9 to serve the Southeastern Palm Beach County Hospital District. Photo courtesy Fort Lauderdale Daily News.



## President Jack Addresses The Florida Bar

Bringing the greetings of the Florida Medical Association, Dr. Ralph W. Jack of Miami, the Association's new President, addressed The Florida Bar at its meeting in Miami Beach on May 22, 1959. He expressed the pleasure of the members of the Association at the friendship that has grown between the two professions and the consequent cooperation that is meeting with gratifying success in solving some of their mutual problems.

In his brief address, Dr. Jack sought the cooperation of the legal profession in coping with one of the nation's greatest problems—accidents, particularly traffic accidents. "It is a matter of some wonderment," he declared, "that the people of this state are served by an estimated 2,000 ministers, or clergy of all denominations, to aid in saving their souls, and 3,634 doctors to help in saving their health, while approximately 8,000 or more lawyers are required to try to save them from each other.

"Man's destruction of man has now reached the proportion of being the third most common cause of death in this country and the first in causation of untimely, premature death."

He directed attention to the great progress that has been made by means of medical research in preserving the good health and prolonging the productive life of man. The first and second leading causes of death at the present time, cardiovascular disease and cancer, are under intense attack by the forces of medical research. The third most common cause, however, "is massively attacking man, and our defenses so far have been relatively ineffective."

In the past, Dr. Jack observed, physicians advised the lawmakers when laws were necessary to protect the health and lives of the people. Such laws involved quarantine measures, vaccination, immunization and the many Public Health regulations at the national, state, county and municipal levels. "Think for a moment if you will of the situation in which we physicians are now placed," he continued. "In the past we have had to discover the laws on which our profession rests. We must discover them, not invent them, for the laws of nature are not to be invented. For the first time in our avowed purpose—the preservation of human life—it appears that the laws necessary to accomplish the required result must be invented.

"Accidents cause a greater mortality and morbidity rate than all of the diseases against

which we now immunize, and traffic accidents take the lead. To attack effectively the ravages of this killer will require the close cooperation of the medical and legal professions to cure the freedom to exercise poor judgment—the cause of the majority of traffic accidents.

"There must be a more careful medical evaluation of licensed vehicle operators and more effective laws to prevent the freedom of incompetent drivers to exercise poor judgment on the highways. The medical profession now solicits the cooperation of the legal profession in a research program to prevent the rapid increase in the number of traffic deaths.

"In the past, the cause of good health has been greatly benefited by the cooperative research of scientists and physicians. To accomplish our mission against accidental death will require a task force in which the legal and medical professions must be the leaders."

In conclusion, Dr. Jack expressed the hope that in the not too distant future an Association president would have the privilege of making a similar request "to some 'association of the clergy' for a cooperative assault on the number one problem now and in the millennium when all problems of health are solved—the saving of men's souls."

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## Postgraduate Obstetric-Pediatric Seminar Daytona Beach, August 20-22, 1959

The Ninth Annual Postgraduate Obstetric-Pediatric Seminar will be held at the Ellinor Village Country Club in Daytona Beach on Thursday, Friday and Saturday, August 20, 21 and 22. Scheduled in August this year instead of September, as formerly, the Seminar is expected to attract pediatricians, obstetricians and general practitioners from four states. The meeting is jointly sponsored by the Bureau of Maternal and Child Health of the State Health Departments of Georgia, South Carolina, Alabama and Florida, and the Maternal Welfare Committees of the State Medical Associations of these four states. The program is approved for postgraduate study, 15 hours, Category I, for members of the American Academy of General Practice. There is no Seminar registration fee.

The lecturers and their subjects are: William A. Cunningham, M.D., Birmingham, Ala., "Hyp-

nosis;" William E. Laupus, M.D., Assistant Professor, Department of Pediatrics, Medical College of Georgia, Augusta, Ga., "Prematurity;" Robert B. Lawson, M.D., Chairman, Department of Pediatrics, University of Miami School of Medicine, Jackson Memorial Hospital, Miami, "Prematurity;" William J. McGanity, M.D., Associate Professor, Department of Obstetrics and Gynecology, Vanderbilt University School of Medicine, Nashville, Tenn., "Nutrition in Pregnancy and Puerperium;" Harrison Picot, M.D., Alexandria, Va., "The Incompetent Cervix;" Harry Prystowsky, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, College of Medicine, University of Florida, Gainesville, "Apnea Neonatorum;" Richard T. Smith, M.D., Professor and Chairman, Department of Pediatrics, College of Medicine, University of Florida, Gainesville, "Newborn Infection;" J. Richard Sosnowski, M.D., Associate Professor, Medical College of South Carolina, Charleston, S. C., "The Pregnant Family;" Frank E. Whitacre, M.D., Vanderbilt University Hospital, Nashville, Tenn., "Forceps-Breech Delivery;" James G. Wilson, Ph.D., Professor of Anatomy, College of Medicine, University of Florida, Gainesville, "Malformations."

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### 108th Annual Meeting American Medical Association Atlantic City, June 8-12, 1959 Delegates' Report

For the first time in its long history, four delegates represented the Florida Medical Association in the House of Delegates of the American Medical Association at its 108th Annual Meeting in Atlantic City on June 8-12. Our interest, along with that of all members of the Association, focused particularly on the Tuesday night inauguration of Dr. Louis M. Orr of Orlando as the 113th president of the American Medical Association. Highlighting this session was the appearance of President Dwight D. Eisenhower, whose address to an overflow audience of some 5,000 was the first ever delivered by a President of the United States before an A.M.A. annual or clinical meeting. President Eisenhower warned that inflation poses the greatest danger to the traditional free enterprise practice of medicine and also expressed gratification on learning of A.M.A. leadership in the program to meet the health care needs of the aged.

The oath of office was administered to Dr. Orr by Dr. Leonard Larson of Bismarck, N. D., Chairman of the Board of Trustees of the American Medical Association. In his inaugural address Dr. Orr affirmed his belief in the basic principles of medicine, democracy and faith under which America's physicians live. He pointed out that freedom must continually be fought for by men and women who are willing to stand up and be counted.

Another feature of the inaugural ceremony was the presentation of the 1959 Distinguished Service Award of the American Medical Association to Dr. Michael E. De Bakey of Houston, Texas. Dr. De Bakey, who is chairman of the department of surgery at Baylor University College of Medicine, received the award for his outstanding contributions in the field of cardiovascular surgery.

At the opening session on Monday morning, Dr. Gunnar Gundersen of LaCrosse, Wis., retiring A.M.A. president, stressed the personal responsibility of every physician to keep abreast of medical advancements and to deliver "1959 medicine." Dr. Orr, then president-elect, called for concerted effort and medical leadership in four areas—the costs of medical care, recruitment of dedicated medical students, basic research, and health care for the aged. At this session the eighth Goldberger Award in clinical nutrition was presented to Dr. Carl V. Moore, Busch professor of medicine at Washington University, St. Louis, and the Smith, Kline and French Laboratories of Philadelphia received a special A.M.A. award for its sponsorship of color medical television over the last 10 years.

Election of officers took place at the Thursday session. Dr. E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect. Dr. Askey will succeed Dr. Orr as president at the association's annual meeting in June 1960 in Miami Beach. Others elected were Dr. James Stanley Kenney of New York City, vice president; Dr. Norman A. Welch of Boston, speaker of the House of Delegates; and Dr. Milford O. Rouse of Dallas, Texas, vice speaker.

Major subjects which brought important policy actions by the House of Delegates included the report of the A.M.A. Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice and the issue of compulsory

*(Continued on page 218)*

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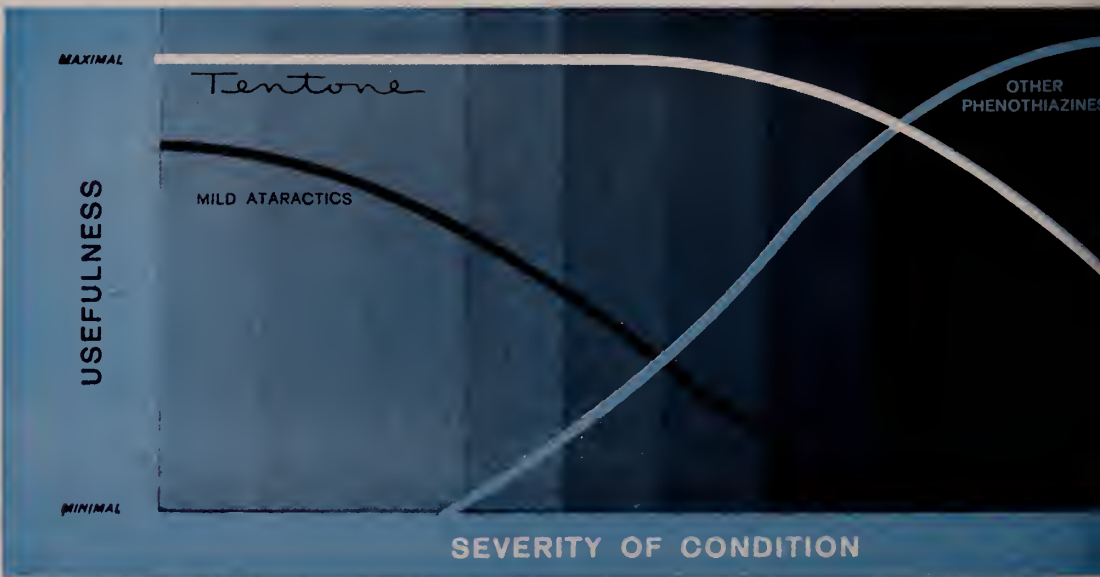
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*(Continued on page 214)*

Social Security coverage for self-employed physicians.

### Commission on Medical Care Plans

The House adopted 36 recommendations of the Commission on Medical Care Plans without change and reworded three. One of the latter, relating to free choice of physicians, now reads: "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives." The House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of another recommendation, which declares: "'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed re-

sponsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

In addition, the House strongly endorsed a recommendation which states: "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care." Many of the recommendations of the Commission urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties.

### Medicine and Osteopathy

The special report of the Judicial Council on the subject of osteopathy led to adoption of the following policy statement regarding interprofessional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical. (B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations. (C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals. (D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including interprofessional relationships on a national level."

In another action relating to osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission on Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

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### Preparation for General Practice

The final report of the Committee on Preparation for General Practice, approved and commended by the House, proposes a new two year internship program for medical school graduates planning to become family physicians. The suggested program provides for a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a broad sense, including care of the newborn. A physician then could elect to spend the remaining six months for additional training in other segments of the program. Participants who plan to practice obstetrics would, however, be expected to spend at least four months of the elective period in obstetric training. The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in outpatient care and emergency room service.

### Social Security

In considering the subject of compulsory Social Security coverage for self-employed physi-

cians, the House adopted a resolution reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the association's entire legislative program, particularly with respect to the Forand Bill.

Recognizing "the apparent growing demand by physicians for economic security," the House requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security."

### Miscellaneous Actions

A wide variety of miscellaneous actions of the House included urging all physicians to participate more fully in community activities and socioeconomic matters in their communities, approving in principle the aims and objectives of the Presi-



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dent's Council on Youth Fitness and the Citizens Advisory Committee on the Fitness of American Youth, requesting the Board of Trustees to study the problems and possibilities of establishing an A.M.A.-sponsored medical scholarship and/or loan program, approving the inclusion of Today's Health as a benefit of dues-paying membership and urging members to make it available to their patients, and recommending that state medical societies, where advisable, initiate legislative efforts to eliminate cancer quackery. The House received a progress report indicating "phenomenal progress" in the field of health insurance coverage for the aged since the Minneapolis meeting last December, reaffirmed its full support of the Educational Council for Foreign Medical Graduates, and urged every A.M.A. member to give a substantial gift to the medical schools through the American Medical Education Foundation.

The total registration through Thursday, with half a day of the meeting still remaining, had reached 28,225, including 12,921 physicians. The 1962 annual meeting will be held in Chicago.

Respectfully submitted,  
Reuben B. Chrisman Jr., M.D.  
Francis T. Holland, M.D.  
Meredith Mallory, M.D.  
Burns A. Dobbins Jr., M.D.

### Registration

BRADENTON: Roy W. Gunther, Sidney Smith, William D. Sugg. BUSHNELL: Karl T. Humes. CLEARWATER: H. Gerald Siek Jr. CLERMONT: Frederick J. Fox. COCOA: Lee Rogers Jr. CORAL GABLES: Reuben B. Chrisman Jr., Victor Dabby, Franklin J. Evans, Joseph Lomax, C. Howard McDevitt Jr., Norman W. McLeod Jr., Irwin Perlmutter, Franklyn E. Verdon, William L. Wagener Jr. CRYSTAL RIVER: Samuel R. Miller Jr. DANIA: Fred E. Brammer. DAYTONA BEACH: John J. Cheleden, Robert H. Freedman, Howard W. Reed. DELRAY BEACH: James R. Nieder. DUNEDIN: Walter H. Winchester. EAU GALIE: Walter Omainsky. FORT LAUDERDALE: Russell B. Carson, Richard R. Ferayorni, George Hamerick Jr., Garland M. Johnson, Richard A. Mills, George T. F. Rahilly, John L. Tomlinson, Joseph W. White. FORT MYERS: H. Quillian Jones. GAINESVILLE: Louis F. Hubener. HOLLYWOOD: Robert R. Harriss, Charlotte E. Mason, Louis J. Novak. HOMESTEAD: Robert A. Douglas. INDIAN ROCK: Warren J. Brown. JACKSONVILLE: Silas M. Copeland, Samuel M. Day, Floyd K. Hurt, Gordon H. Ira, A. Mackenzie Manson, Wilson T. Sowder. KISSIMMEE: John O. Rao. LAKE LAND: Jere W. Annis, Ben H. McConnell Jr. LARGO: Lawrence G. Patterson. LEESBURG: George E. Engelhard.

MARIANNA: Terry Bird, Albert E. McQuagge. MIAMI: Lawrence Adler, Harvey Blank, John E. Burch, Francis N. Cooke, Milton M. Coplan, Carl H. Davis, Byron D. Epstein, James E. Fischer, M. Jay Flipse, Roger J. Forastiere, Manuel A. Gonzalez, A. Gorman Hills, David S. Howell, Ralph W. Jack, Arnold L. Kane, Carlos P. Lamar, Morris J. Levine, George D. Lilly, Wayne B. Martin, E. Sterling Nichol, Colquitt Pearson,

(Continued on page 228)

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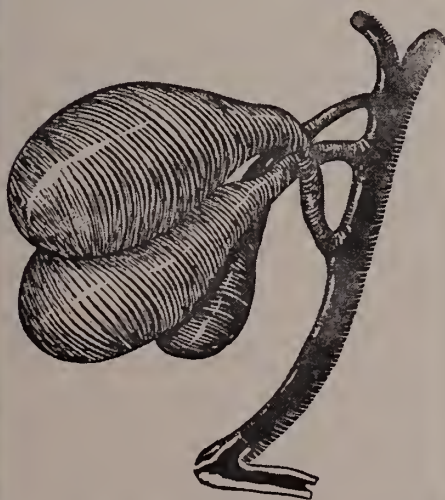
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Source: Skilboe, B.: Am. J. Clin. Path. 30:252, 1958.



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- (1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.  
(2) Biliary Tract Diseases, M. Times 85:1081, 1957.

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<sup>1</sup> Rubin, W. and Anderson, J. B.: *Angiology*, Oct. 1958.



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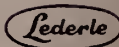
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(Continued from page 222)

Homer L. Pearson Jr., Earl M. Peck, Max Pepper, William C. Phillips, Harold Rand, Maurice J. Rose, Walter W. Sackett Jr., Wiley M. Sams, George F. Schmitt Jr., J. Graham Smith Jr., Richard F. Stover, Edward H. Williams. MIAMI BEACH: Mortimer D. Abraskin, Abraham R. Hollender, Allan A. Kaplan, Harold S. Kaufman, Maurice D. Krauss, Alexander Libow, Robert R. Rosenblum, Sylvan A. Schotz, Nicholas A. Tierney, Leonard L. Weil. ORLANDO: Benjamin M. Cole, Elwyn Evans, Frank D. Gray, Newton C. McCollough, Meredith Mallory, John G. Marsh, Pleasant L. Moon, Louis E. Pohlman, Robert L. Tolle.

PALM BEACH: Fred E. Manulis, Alvin E. Murphy. PANAMA CITY: Clark A. Whitehorn. QUINCY: Taylor W. Griffin. ST. PETERSBURG: Arnold S. Anderson, Arthur Appleyard Jr., Walter H. Bailey, Elmer B. Campbell, Harry R. Cushman, Chas. K. Donegan, Cornelius S. Franckle, Paul S. Herr, James K. McCorkle, Samuel Myerson, Nell T. Pattengale, J. Braden Quicksall, Richard Reeser Jr., Melvin S. Robinson. SANFORD: Edwin Epstein, John E. Morgan. SARASOTA: John M. Butcher, Thomas R. Young Jr. TALLAHASSEE: Joseph M. Bistowish Jr., Francis T. Holland, George H. McCain. TAMPA: Frank S. Adamo, Lee J. Cordrey, Wm. P. Duncan, J. Brown Farrior, H. Phillip Hampton, Joseph E. Harlow, A. M. C. Jobson, Eunice M. Lasche, Neal J. Phillips, Roy F. Saxon Jr., John T. Wright. VENICE: Talmadge S. Thompson. VERO BEACH: Erasmus B. Hardee, James C. Robertson. W. PALM BEACH: Theodore Norley, Ralph M. Overstreet Jr., James C. White. WINTER HAVEN: Theodore C. Keramidas.

## OTHERS ARE SAYING

### Medical Practice in This Changing World

When he delivered an address\* at the dedication ceremonies of the Nassau Academy of Medicine, among other things Dr. Louis H. Bauer said:

There is something I said when I was inaugurated president of the A.M.A. and I'm going to repeat it. Thomas Jefferson fought against too much power in central government, but supported the centralized government and freedom of individual citizens. Slowly but surely, one by one, we are losing those freedoms guaranteed by the Bill of Rights. Personal liberties are being traded for government subsidies. We are selling our birthrights for a mess of pottage. Unless we watch out we shall suddenly wake up to find that we have traded liberty for shackles, the shackles of destructive, confiscatory taxation. The shackles of complete dependence upon government for everything in life. The shackles of suppression of initiative in competition. The shackles of the suppression of a free press and free speech. Now I'm afraid that it is still true today and I think we are in increasing danger. At the same time I quoted the following, which I'll quote again. About one hundred years ago Daniel Webster said, "It were but a trifle even if the walls of yonder castle were to crumble, if its lofty pillars

\*December 7, 1958

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"Ability to decide correctly has increased, while the illogical response to anxiety has diminished."<sup>1</sup>

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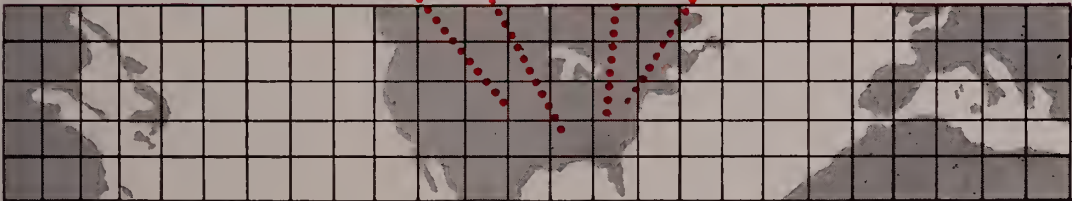
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery"<sup>3</sup>

IN PEDIATRICS

"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior..."<sup>2</sup>

IN GENERAL

ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."<sup>4</sup>



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

• Supplied: Tablets, bottles of 100. Syrup, pint bottles.  
• Parenteral Solution, 10 cc. multiple-dose vials.

• References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958.  
• 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956.  
• 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

ATARAX



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Science for the World's Well-Being

should fall, and its gorgeous decorations be all covered by the dust of the valley. All these may be rebuilt but who shall reconstruct the fabric of demolished government? Who shall rear again the well proportioned columns of constitutional liberty? Who shall frame together the skilled architecture which unites national sovereignty with states rights, individual security and public prosperity. No, if these columns fall they will be raised not again."†

If anyone is qualified to speak authoritatively about what goes on in medicine all over the world, Dr. Bauer as Secretary-General of the United States Committee of the World Medical Association is preeminently so qualified. He has observed the effect on the practice of medicine of governmental subsidies and control at first hand and warns the profession here against the sure consequences of indifference and disunity which in the case of Great Britain contributed to the formation of the National Health Service which has skyrocketed costs so that the "average Britisher pays 43 per cent of his income in taxation. . ."

It has been said that "nothing is certain but death and taxes." Incontrovertibly true; at the

time this was written the canny Benjamin Franklin (1789) in a letter to M. Leroy was discussing our Constitution of which he wrote that "it is in actual operation; everything *appears* to promise that it will last; but in this world nothing is certain but death and taxes." At that time the average life span during which an individual had to pay his taxes before death relieved him of the burden was much less than now and death duties and estate taxes such as we have at present did not exist. Let anyone think back over the one hundred seventy years between and see what has happened to this Republic. Again, just after the constitution had been ratified it is said that a lady asked Dr. Franklin: "Sir, what kind of a government have we?" To which he replied: "Madam, you have a Republic—if you can keep it."

The passing years have seen rapidly expanding government because citizens have demanded more and more services in nearly every category from this source. They seem unaware that the important thing is not what government does for you but what it does to you. No one gets something for nothing. Dr. Franklin seems to have had some reservations respecting the durability of our Constitution. Many of us have lived to

†Nassau M. News, 31:3 (Feb.) 1959.

(Continued on page 234)



Sanctorius on his steelyard chair in the act of weighing himself for a metabolism experiment

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bring the . . . MOOD UP  
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Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.



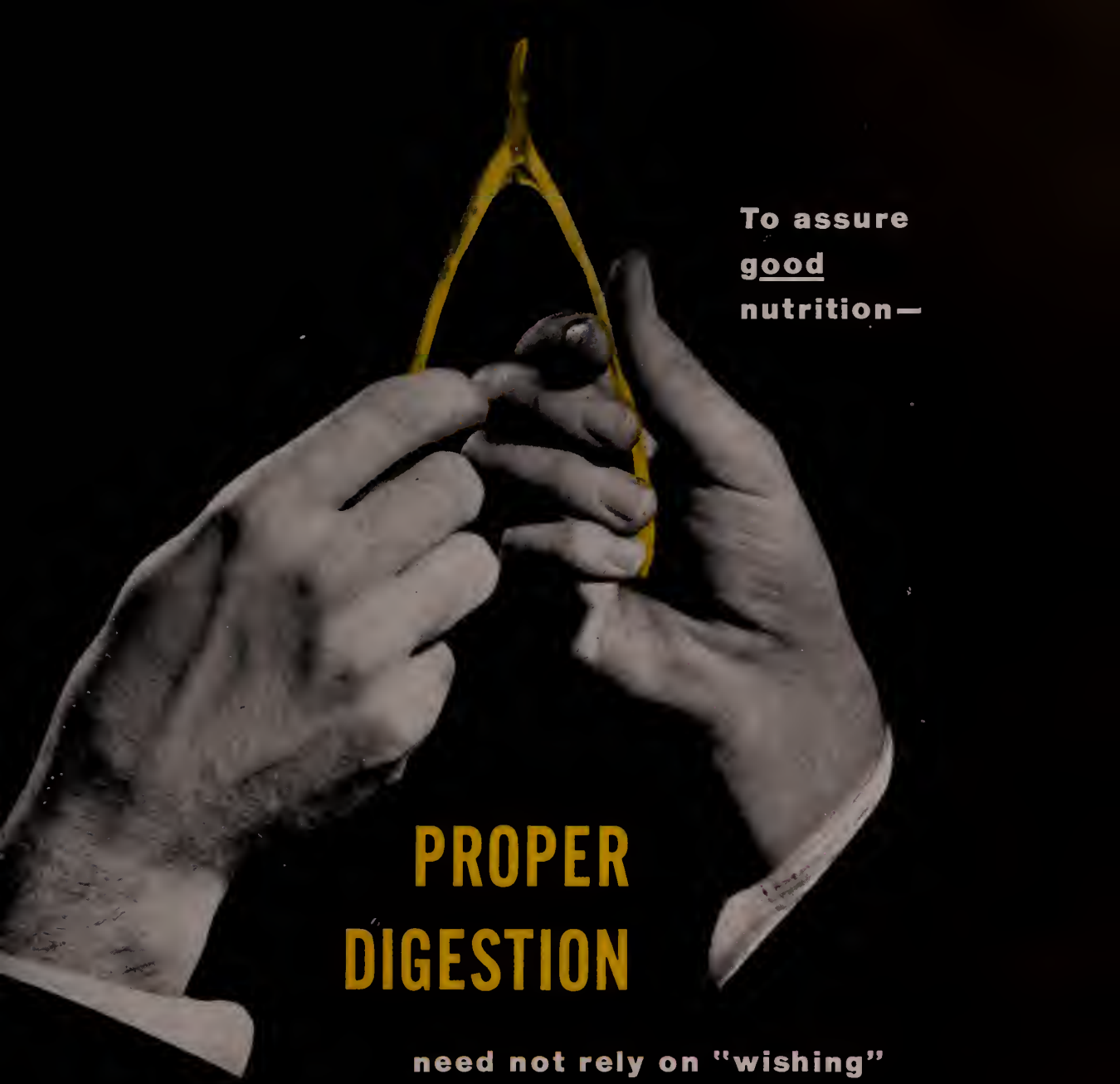
PAGE 826

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the mood brightener

Lifts the  
burden of  
depression...  
opens the way  
for a sunnier  
outlook

## New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involuntal melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, whether due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

## New safety

The outstanding safety of NIAMID in extensive clinical trials eliminates the hepatotoxic reaction observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.


Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

## Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these mood depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine proportionately.

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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

## Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

## Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

## Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

## References

Complete bibliography and Professional Information Booklet are available on request.

\*TRADEMARK FOR BRAND OF NIALAMIDE



**NIAMID**  
*the mood brightener*



*(Continued from page 230)*

see States' right seriously invaded by the Federal government and the guarantees of the Bill of Rights eroded as Dr. Bauer observes. Many facets of medicine are already directly or indirectly under government control. The camel has his nose in the tent. How long before he gets all the way in?

*New York State Journal of Medicine*  
Vol. 59, April 15, 1959.

### NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Cuevas, Gabino S., Fort Lauderdale  
Drewry, Garth R., Tampa  
Foster, Donald H., Tampa  
George, William S., Coral Gables  
Gomez, Max E., Miami  
Harrison, Henry T., Ocoee  
Hill, Harold D., Fort Lauderdale  
Siers, Mary R., Fort Lauderdale  
Tompkins, William A., Fort Lauderdale

### BIRTHS AND DEATHS

#### Births

Dr. and Mrs. Thomas S. Edwards of Jacksonville announce the birth of a son, Thomas S. Edwards, Jr. on May 31, 1959.

#### Deaths—Members

Bernstein, Clarence, Orlando ..... April 23, 1959  
Floyd, George M., Hawthorne ..... Feb. 17, 1959  
Edwards, Howard K., Miami ..... April 19, 1959  
Ross, William E., Jacksonville ..... May 16, 1959  
Sullivan, Rosa L., Pensacola ..... April 4, 1959  
Taylor, Byrne E., Orlando ..... June 14, 1959  
Weber, Henry C., Drexel Hill, Pa. .... Oct. 30, 1958

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## STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando, President of the American Medical Association, participated in the scientific program of the 13th Annual Rocky Mountain Cancer Conference held July 22-23 at Denver, Colo. The title of Dr. Orr's presentation was "Cancer of the Prostate."

Dr. Clifford C. Snyder of Miami is on a tour of several European countries visiting clinics and hospitals. The middle of June he was in Moscow and expected to go from there to Vienna.

Dr. Fred Mathers of Orlando has been reappointed as a member of the Crippled Children's Commission by Governor LeRoy Collins.

Dr. John E. Schwab of West Palm Beach was among the group of Florida physicians who attended the annual meeting of the Harvey Cushing Society held the latter part of April and the first of May in New Orleans.

Drs. Morris B. Seltzer of Daytona Beach, George S. Palmer of Tallahassee and Frank D.

Gray of Orlando have been reappointed by Governor LeRoy Collins as members of the State Board of Medical Examiners.

Dr. Arnold S. Anderson of St. Petersburg has been reelected Regent for Florida of the American College of Chest Physicians, and Dr. Alexander Libow of Miami Beach has been reelected Governor of the College for the state. They were selected at the 25th annual meeting held June 3-7 at Atlantic City.

The Eighth Congress of the Pan-Pacific Surgical Association will be held September 28 through October 5 in Honolulu, Hawaii. Information may be obtained from Dr. F. J. Pinkerton, Director General, Suite 230, Alexander Young Bldg., Honolulu 13, Hawaii.

Dr. Robert J. Boucek of Miami Beach has been installed as president of the Heart Association of Greater Miami. Other newly elected officers include Drs. Martin S. Belle and William M. Straight of Miami, vice presidents; Dr. Francisco A. Hernandez of Miami, secretary, and Dr. Edward W. St. Mary of Miami, treasurer. Dr.

(Continued on page 244)

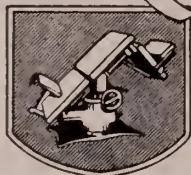


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TO: EMOTIONAL  
STABILITY**

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SQUIBB TRIFLUPROMAZINE HYDROCHLORIDE

made the difference  
in anxiety and tension states / psychomotor agitation /  
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wide variety of physical conditions

In the patient with anxiety and tension symptoms — Vesprin calms him down without slowing him up...and does not interfere with his working capacity. Vesprin permits tranquilization *without* oversedation, lethargy, apathy or loss of mental clarity.<sup>4</sup>

And Vesprin exhibits an improved therapeutic ratio — enhanced efficacy with a low incidence of side effects; no reported hypotension, extrapyramidal symptoms, blood dyscrasia or jaundice in patients treated for anxiety and tension.<sup>1,2,3</sup>

**dosage:** for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy 3:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. 24:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes 2:3, 1959. 4. Kris, E.: Clinical Research Notes 2:1, 1959. VESPRIN® is a Squibb Trademark

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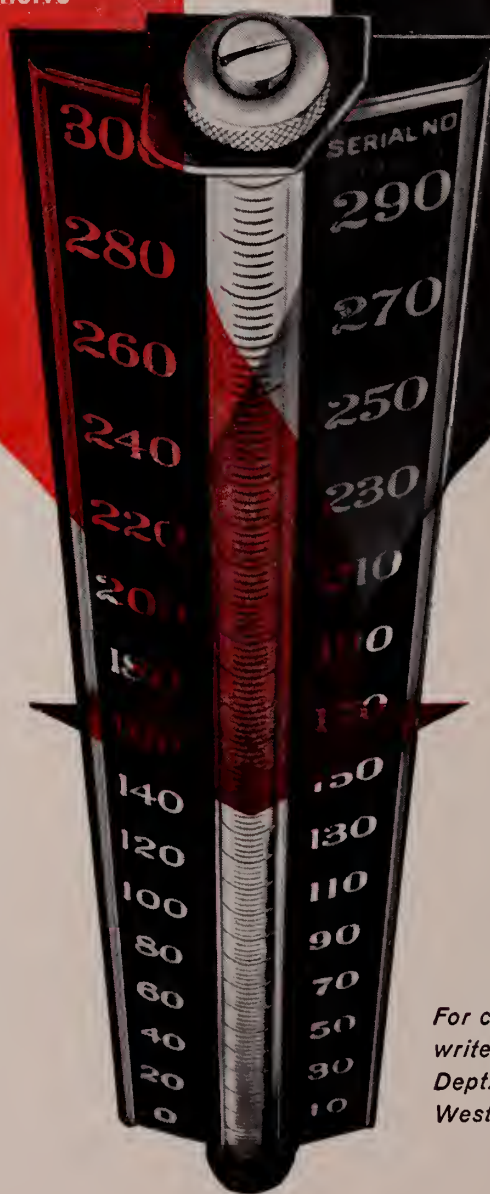
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much more effective  
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- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
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- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

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25 mg. HYDRODIURIL, 0.125 mg. reserpine.  
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50 mg. HYDRODIURIL, 0.125 mg. reserpine.  
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If the patient is receiving ganglion blocking drugs or hydralazine,  
their dosage must be cut in half when HYDROPRES is added.



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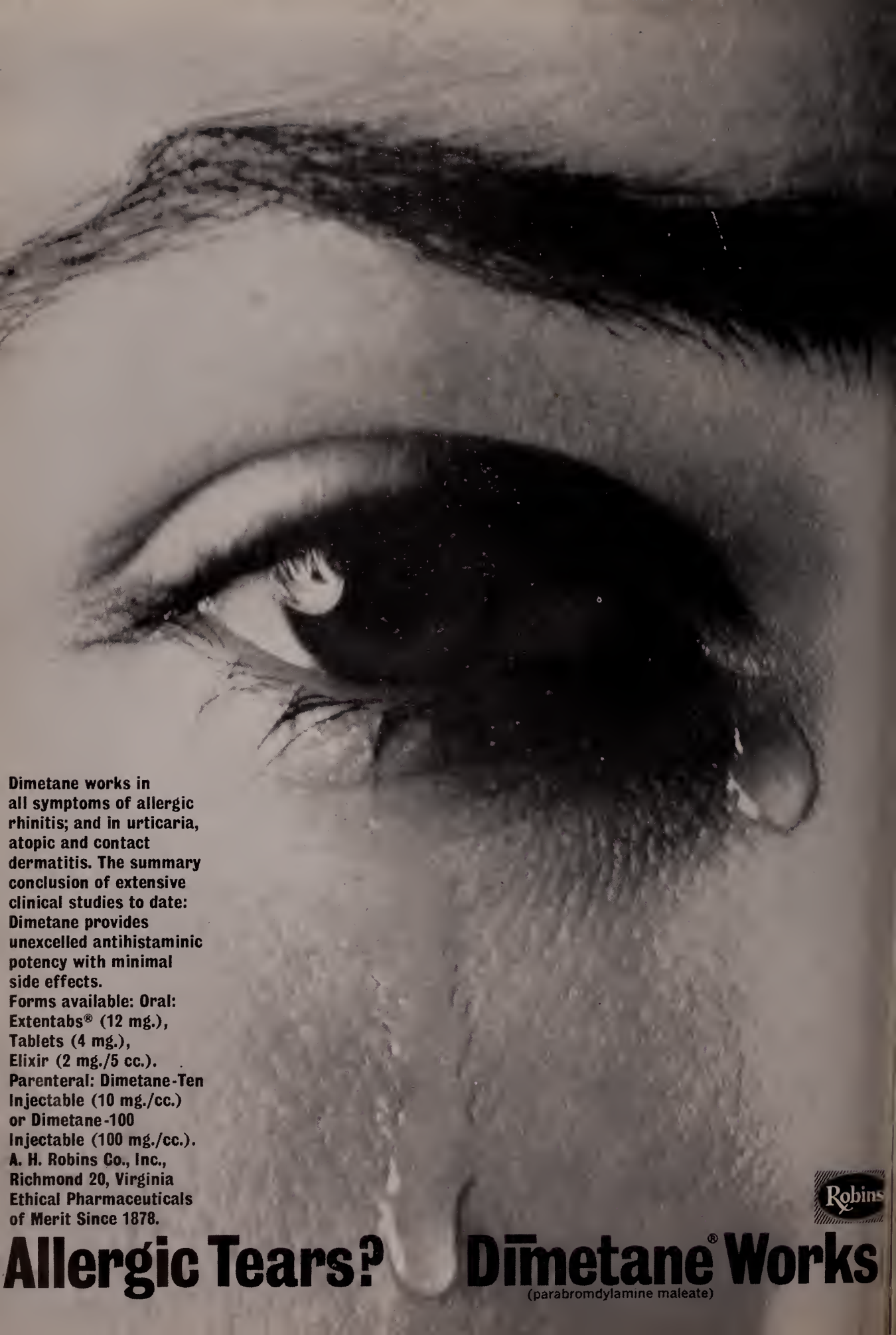
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Division, Chas. Pfizer & Co., Inc.  
Brooklyn 6, New York

References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

\*Trademark

(Continued from page 236)

Jean J. Perdue of Miami Beach was chosen president-elect.

Dr. Walter W. Weigel of Palatka has returned from Boston where he attended postgraduate courses at Peter Bent Brigham Hospital and the Harvard Medical School.

Dr. Sidney Davidson of Lake Worth has been installed as president of the Florida Heart Association. Dr. Claude G. Hooten Jr. of Clearwater has been chosen as president-elect. Other officers chosen at the recent tenth annual meeting held in Miami included Dr. Daniel R. Usdin of Jacksonville, first vice president, and Dr. John M. Packard of Pensacola, second vice president.

Dr. M. Jay Flipse of Miami has been chosen as president-elect of the American College of Chest Physicians. The election of Dr. Flipse took place at the 25th annual meeting of the College held June 3-7 at Atlantic City.

Dr. Frederic H. Wood of Bradenton was principal speaker at the recent meeting of Division 16, Licensed Practical Nurses Association, held in

that city. Dr. Wood discussed prostatic diseases and prostatic surgery.

Dr. Daniel B. Langley of Naples has been elected president of the Collier County unit of the American Cancer Society. Dr. John J. Meli also of Naples was chosen as professional vice president.

Dr. Harold O. Hallstrand of South Miami is a member of the program committee for the 24th annual congress of the North American Federation of the International College of Surgeons being held September 13-17 in the Palmer House, Chicago.

Dr. Howard M. DuBose of Lakeland represented the Florida Trudeau Society at the recent annual meeting of the American Trudeau Society held at Chicago.

Dr. Ernest R. Bourkard of Tampa is serving as president of the newly formed Southwest Florida Psychiatric Society, and Dr. Walter H. Wellborn Jr. as secretary-treasurer. Dr. Joseph J. Regan of St. Petersburg is president-elect.

If he needs nutritional support...



he deserves

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# NICOZOL<sup>®</sup>

ORIGINAL FORMULA

The ideal cerebral tonic and stimulant for the aged.

NICOZOL therapy (the original formula) affords prompt relief of apathy. Patients generally look better, feel better; become more cooperative, cheerful and easier to manage.  
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and nicotinic acid

For relief of agitation and hostility:  
NICOZOL with reserpine Tablets

Supply: Capsules • Elixir



see  
Page 666

**DRUG**  
*Specialties*  
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WINSTON-SALEM 1, NORTH CAROLINA



Dr. Richard G. Connar of Tampa has been elected chairman of the board of the Hillsborough County Heart Association. Other officers include Dr. Louis E. Cimino, vice president, and Drs. Ernest A. Reiner and Robert G. Sherrill Jr. members of the executive committee. Drs. Reiner and Sherrill are also from Tampa.

Dr. Charles H. Lasley of Clearwater was among the group of Florida physicians attending the recent annual meeting of the American College of Chest Physicians held in Atlantic City.

Dr. J. Brown Farrior has been presented the Billings gold medal for his exhibit "Ear Surgery in 3-D: Tympanoplasty, Stapes and Fenestration" which was shown at the recent annual meeting of the American Medical Association in Atlantic City. Dr. Farrior's exhibit received the award on the basis of excellence of correlating facts and presentation.

Dr. Clarence M. Sharp of Jacksonville was elevated to the position of assistant state health officer on July 1 to concentrate primarily on administrative work. The post is similar to that held by Dr. Albert V. Hardy who is concerned with research, development and training programs.

Dr. William F. Enneking has been appointed Associate Professor of Surgery and Chief of Orthopedic Surgery at the College of Medicine, University of Florida, Gainesville. He was formerly professor and director of the Division of Orthopedic Surgery at the University of Mississippi Medical Center.

The Tennessee Valley Medical Assembly is scheduled for September 28-29 at the Read House, Chattanooga, Tenn. One of the featured speakers is Dr. Louis M. Orr of Orlando, president of the American Medical Association, whose topic is "The Decisive Edge."

Dr. Nicholas Robert Greville has been appointed Assistant Professor of Orthopedic Surgery at the College of Medicine, University of Florida, Gainesville. He was formerly an associate in orthopedics in the Department of Surgery at Emory University.

### Medical Officer Returned

Dr. Albert B. Russell Jr., who entered military service on June 6, 1957, was released from active duty on June 4, 1959, with the rank of lieutenant commander, U. S. Naval Reserve. His address is Huey P. Long Hospital, Pineville, La.

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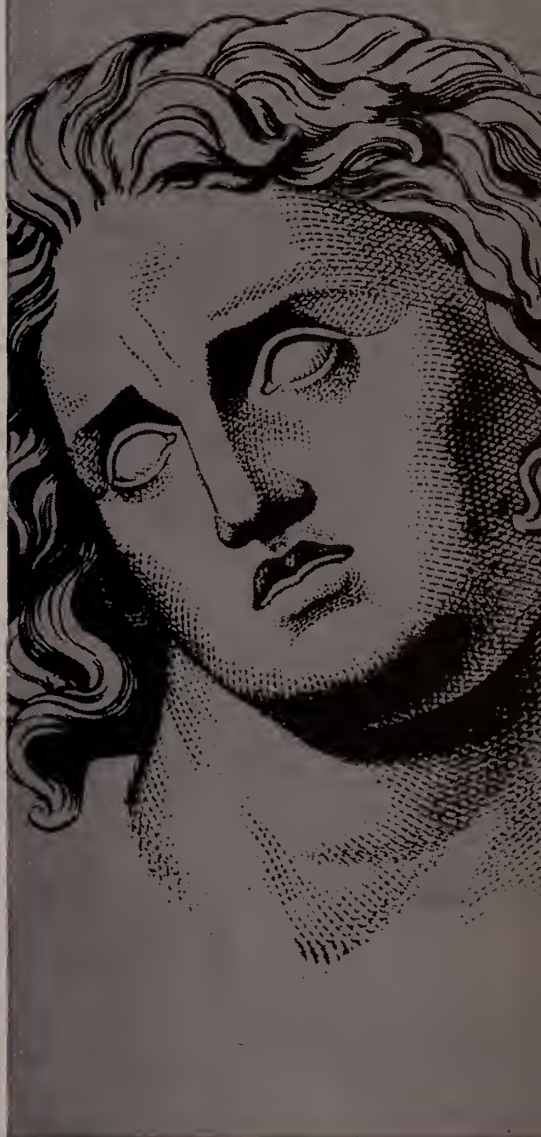
CAPSULES—14 VITAMINS—11 MINERALS

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Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

in premenstrual tension  
only neo Bromth<sup>®</sup>  
treats the whole syndrome



It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

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# avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4,5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2,4,5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

**CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage**



Regular aspirin crystals 24 hours after being mixed into water.

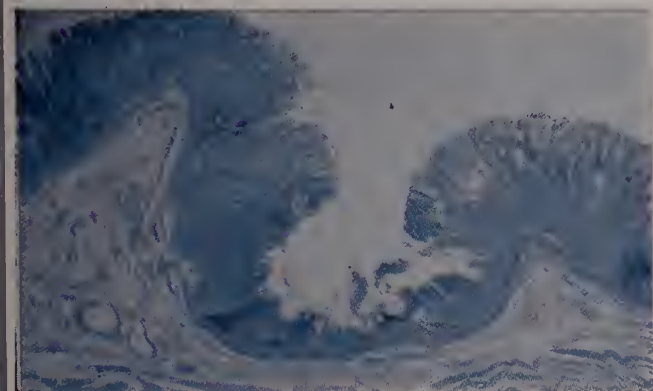


Calurin crystals in solution one minute after being mixed into water.

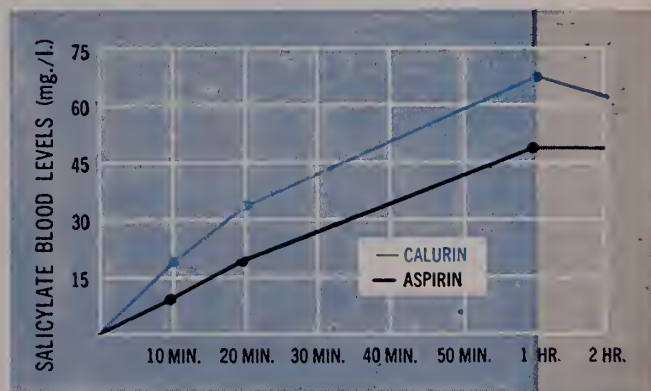


# CALURIN\*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



**Particle-induced ulceration**—section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
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**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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That wonderful moment when "you're on your own". . .

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GOOD GOING! Now you've "got the hang of it". . . now you know how to water-ski. And later on, it's really great to relax with a good glass of cold beer. No other beverage hits the spot like beer—nothing is so rewarding. And a glass of beer really picks you up too.

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## LIQUID

the newest antiarthritic,  
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- without the disturbing  
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*ARTHROPAN Liquid... "born of a therapeutic need"... The need was for a better antiarthritic agent — an agent free of the therapeutic limitations and the discomforting or potentially dangerous side effects associated with usual therapies... Under development for several years, ARTHROPAN has been studied in several thousand patients by more than 180 investigators and is currently being evaluated in many different disorders... The rapid effectiveness, the comfortable and constant action, and the certain safety of new ARTHROPAN Liquid are established as clinical facts... ARTHROPAN breaks through therapeutic barriers and offers the arthritic patient new vistas in successful therapy of arthritis.*

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## OBITUARIES

### Howard Keay Edwards

Dr. Howard Keay Edwards of Miami died on April 19, 1959, near Tahoe, Calif., when stricken by a heart attack. He was 48 years of age. Burial took place in Miami on April 23.

Born in London, England, in 1910, Dr. Edwards came to Roselle, N. J., with his parents nine months later. At the age of 16 he moved to Coral Gables, where he finished his preliminary schooling at Ponce de Leon High School. Matriculating first at the University of Florida, where he was a Pi Kappa Alpha, he later received his B.A. degree at the University of Miami in 1932. After two years of study at the Medical College of Alabama in Birmingham and two years at Washington University School of Medicine in St. Louis, he was awarded his medical degree and became the first University of Miami graduate to receive an M.D. degree from a then accredited medical school.

Returning to Miami, Dr. Edwards interned at the Jackson Memorial Hospital and then served a residency at the Dade County Hospital in Kendall. For a short time he was associated with

Dr. Ralph N. Greene, Medical Director of Eastern Air Lines, and after Dr. Greene's untimely death he succeeded him in that post, a position he continued to hold until death claimed him. In this capacity, he developed and propounded many of the basic concepts in aeronautical medicine. In 1948 and 1949 he served as president of the Air Line Medical Directors Association. At the time of his death he was en route to Los Angeles to attend a meeting of airline physicians.

Dr. Edwards was a member of the Dade County Medical Association and since 1938 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and was a fellow of the College of Chest Physicians and of the Association of Preventive Medicine.

In 1938, Dr. Edwards was married to Miss Leola Peters, the daughter of Dr. Edgar Peters, a pioneer in Dade County medicine, and with whom he was associated in practice. In addition to the widow, two sons, H. Keay and Jock Edwards, survive him, and also two brothers, Dr. Robert V. Edwards, of Coral Gables, and Dr. William Edwards, a dentist of Fort Lauderdale; and a sister, Mrs. Yates Songer, of Coral Gables.

*(Continued on page 262)*

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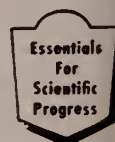
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... Just one dose sustains plasma-tissue levels for  
... 2 hours. Sensitivity reactions and renal toxicity  
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## ACETYL PEDIATRIC SUSPENSION

N<sup>1</sup> Acetyl Sulfamethoxy pyridazine

**Recommended dosage:** First-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer after a meal.


**Supplied:** Each teaspoonful (5 cc.) contains 250 mg. of sulfamethoxy pyridazine activity. Bottles of 4 and 16 fl. oz.

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# "finger-itis"

**there's pain and  
inflammation here...  
it could be mild  
or severe, acute  
or chronic, primary  
or secondary  
fibrositis—or even  
early rheumatoid  
arthritis**

more potent and  
comprehensive  
treatment than  
salicylate alone

... assured anti-inflammatory  
effect of low-dosage  
corticosteroid<sup>1</sup>

... additive antirheumatic  
action of corticosteroid  
plus salicylate<sup>2-5</sup> brings  
rapid pain relief; aids  
restoration of function.

... wide range of application  
including the entire  
fibrositis syndrome  
as well as early or mild  
rheumatoid arthritis

**more manageable  
corticosteroid dosage**

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of treatment-interruption  
side effects<sup>1-6</sup>

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dosage schedule





in any case  
it calls for  
**Sigmagen<sup>®</sup>**  
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te conditions: Two or three  
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**Composition**

METICORTEN® (prednisone) .....	0.75 mg.
Acetylsalicylic acid .....	325 mg.
Aluminum hydroxide .....	75 mg.
Ascorbic acid .....	20 mg.

**Packaging:** SIGMAGEN Tablets, bottles of 100 and 1000.

**References:** 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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# KENT'S SUPER-POROUS MICROPORE PAPER

With the intensive publicity being given to porous cigarette paper in recent weeks, Kent believes that doctors would be interested in knowing the scientific facts about the paper used in today's Kent cigarettes.

Kent's exclusive super-porous Micropore paper lets cool air in, lets heat escape through microscopic pores in the paper. The increased oxygen in the tobacco cylinder brings about more complete combustion of the tobaccos. As a result, Kent smokers have been getting a cooler, cleaner, fresher taste in smoking.

When the advantages of Kent's Micropore paper are coupled to Kent's other superiorities, it is easy to understand why more people, during the past year, changed to Kent

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Kent smokers also enjoy a free and easy draw, which brings through the rich taste of Kent's costly blend of 100% natural tobaccos. In addition, Kent's exclusive Micronite Filter has made a significant contribution in the area of filtration: Kent has reduced tars and nicotine to the lowest level among all leading brands.

The American smoking public was quick to respond to Kent. They discovered—it makes good sense to smoke Kent, and good smoking, too.



If you would like for your own use the booklet, "The Story of Kent," write to:  
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extends the range of relief in HAY FEVER

usual medications  
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**isoclor**

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to relieve both nasal  
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provides both . . . / upper respiratory decongestion  
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Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

**COMBINES** the nasal and bronchial decongestant action of d-isoeephedrine with the histamine blocking action of chlorpheniramine.

**RELIEVES** the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—let's the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

TABLETS AND SYRUP for adults and children . . .

COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate	4 mg.	2 mg.
d-Isoeephedrine HCl	25 mg.	12.5 mg.

DOSE: Tablets: One tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d.; Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

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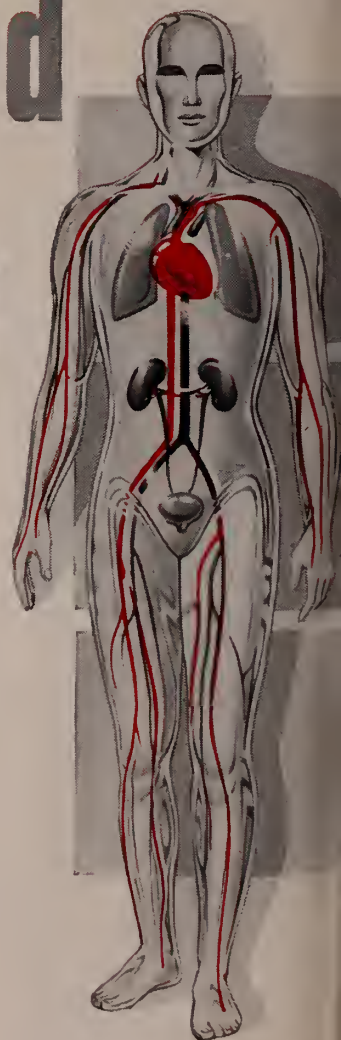
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**Initiate therapy with HYDRODIURIL:** one 25 mg. tablet or one 50 mg. tablet once or twice a day. HYDRODIURIL by itself often causes an adequate drop in blood pressure over a period of two to three weeks. This may be all the therapy some patients require.

**Add or adjust other agents as required:** HYDRODIURIL enhances the activity of all commonly-used antihypertensive agents; thus, the dosage of other medication (rauwolfia, reserpine, hydralazine, veratrum) should be initiated or adjusted as indicated by patient condition. If a ganglion-blocking agent is contemplated or being used, usual dosage must be reduced by 50 per cent.

**Adjust dosage of all medication:** the patient must be frequently observed and careful adjustment of all agents should be made to establish optimal maintenance dosage.

**Supplied:** 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000. Additional literature for the physician is available on request.

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(Continued from page 254)

**Francis Joseph McNally**

Dr. Francis Joseph McNally of Pompano Beach died unexpectedly on April 22, 1959, following a heart attack. He was 40 years of age.

Born in Springfield, Mass., on March 1, 1919, Dr. McNally received his premedical education at Williams College in his native state, was graduated from Columbia University College of Physicians and Surgeons in 1944 and then served an internship at Bellevue Hospital in New York City. During World War II he served three years in Germany as a captain in the United States Army Medical Corps. After the war he spent six additional years in surgical residency training, divided between Postgraduate Hospital, New York City, City Hospital of Cleveland, Ohio, and Sunny Acres Sanatorium, Warrensville, Ohio. He then returned to Massachusetts to engage in the private practice of surgery in Springfield.

Locating in Florida in the spring of 1954, Dr. McNally became the first surgeon to open an office in Pompano Beach. In five years of most successful practice there, he engaged in many civic interests and devoted much time to the improvement of hospital facilities and patient care. Shortly before his untimely death, he had finished

serving two years as president of the staff of Holy Cross Hospital and was active on many committees there. He was also working with the North Broward Hospital Commission in establishing the North Broward District Hospital in Pompano, which was under construction.

Dr. McNally was a member of the Broward County Medical Association and of the Florida Medical Association. He also held membership in the American Medical Association and societies of his specialty.

In 1955, Dr. McNally was married to Miss Virginia Hall, who survives him. Also surviving are a daughter, Elizabeth, aged two years; a sister, Mrs. Richard Truelsen, of Flemington, N. J.; and two brothers, Dr. John McNally and Edmund McNally, both of Massachusetts.

**George Matthew Floyd**

Dr. George Matthew Floyd of Hawthorne died at the Alachua General Hospital in Gainesville on Feb. 17, 1959, after a brief illness. He was 77 years of age. Following funeral services at the Hawthorne Methodist Church, interment took place in Evergreen Cemetery in Gainesville.

A native Floridian, Dr. Floyd was born near Fort White in Columbia County on Nov. 17,

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Intrinsic Factor Concentrate . . . . .	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B <sub>1</sub> ) . . . . .	5 mg.
Riboflavin (B <sub>2</sub> ) . . . . .	5 mg.
Niacinamide . . . . .	15 mg.
Folic Acid . . . . .	1 mg.
Pyridoxine HCl (B <sub>6</sub> ) . . . . .	0.5 mg.
Ca Pantothenate . . . . .	5 mg.
Choline Bitartrate . . . . .	50 mg.
Inositol . . . . .	50 mg.
Ascorbic Acid (C) . . . . .	50 mg.
Vitamin E (as tocopheryl acetates) . . . . .	10 I.U.
L-Lysine Monohydrochloride . . . . .	25 mg.
Rutin . . . . .	25 mg.
Ferrous Fumarate . . . . .	30 mg.
Iron (as Fumarate) . . . . .	10 mg.
Iodine (as KI) . . . . .	0.1 mg.
Calcium (as CaHPO <sub>4</sub> ) . . . . .	157 mg.
Phosphorus (as CaHPO <sub>4</sub> ) . . . . .	122 mg.
Boron (as Na <sub>2</sub> B <sub>4</sub> O <sub>7</sub> ·10H <sub>2</sub> O) . . . . .	0.1 mg.
Copper (as CuO) . . . . .	1 mg.
Fluorine (as CaF <sub>2</sub> ) . . . . .	0.1 mg.
Manganese (as MnO <sub>2</sub> ) . . . . .	1 mg.
Magnesium (as MgO) . . . . .	1 mg.
Potassium (as K <sub>2</sub> SO <sub>4</sub> ) . . . . .	5 mg.
Zinc (as ZnO) . . . . .	0.5 mg.



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wholesomeness,  
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Coca-Cola as  
refreshment has helped  
make Coke the  
best-loved sparkling  
drink in all the world.



SIGN OF GOOD TASTE



1881. He received his academic education at Normal College, Abbeville, Ala., Palmer College, and Tulane University. For his medical training he entered the Atlanta College of Physicians and Surgeons, later Emory University, and was awarded the degree of Doctor of Medicine by that institution in 1909.

For more than four decades the only practicing physician in Hawthorne, Dr. Floyd located there on June 10, 1909. He was accompanied by his wife, a trained nurse, who was to give the only expert assistance the doctor had during his long tenure as the only physician "in a broad blackjack and slash pine land stretching from Gainesville to Palatka and into the 'Scrub.'" In those horse-and-buggy days of medical practice, the nearest hospital, until 1927, was in Jacksonville, and patients on cots were transported there by train, Dr. Floyd accompanying them in the baggage car. Special tribute was paid this general practitioner of the old school on Sunday, June 10, 1951, when more than 2,000 persons, many of them "Dr. Floyd's babies," gathered at the Hawthorne High School auditorium for joint

services, followed by a mass picnic on the grounds. Speaker after speaker extolled the virtues of the beloved "country doctor" so perfectly exemplified in Dr. Floyd.

Dr. Floyd was a member of the Alachua County Medical Society and was a life member of the Florida Medical Association, having been a member for 49 years. He also held membership in the American Medical Association.

Surviving are a daughter, Mrs. Frederick E. Gehan, and a granddaughter, Miss Julia Floyd Gehan, both of Gainesville; and a sister, Mrs. Mattie F. Collins, of Lake City. Mrs. Floyd died in 1953.

### BOOKS RECEIVED

**Preventive Medicine in World War II, Volume IV, Communicable Diseases Transmitted Chiefly Through Respiratory and Alimentary Tracts.** Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D. Pp. 544. Price, \$5.50. Washington, D.C., Office of the Surgeon General, Department of the Army, 1958.

This is another in the professional series of the volumes comprising the official history of the Medical Department of the United States Army in World War II. It deals

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Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can be used separately as a wall cabinet and the lower section as a treatment stand. This option allows a greater variety of room arrangement according to personal preference and requirements.

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comprehensively from a broad preventive medicine viewpoint, worldwide in scope, with diseases transmitted through the respiratory and alimentary tracts. Although military preventive medicine has greatly broadened its scope, the control of communicable diseases continues to be the central activity. In this volume and two to follow, the primary objectives are to indicate the magnitude of the communicable disease factor in United States Army operations in World War II and to define and characterize the problems of communicable disease in military practice as distinct from those of civilian life. This volume contains a wealth of authoritative, detailed epidemiologic information and carefully collected and evaluated supporting data, and also extensive illustrations, tables, and charts. The authors of the 24 chapters were chosen because of their experience and distinction in their special fields.

**Vascular Surgery.** By Geza de Takats, M.D., M.S., F.A.C.S. Pp. 726. Illus. 382. Price, \$17.50. Philadelphia, W. B. Saunders Company, 1959.

The purpose of this book is to describe the experience of the distinguished author and his group at the University of Illinois College of Medicine, where he is Clinical Professor of Surgery. "It is only through a good backward look into the development of vascular surgery in our own institution," he comments in the Preface, "that the present advances can be understood and assessed. As in any other surgical endeavors, technical skill is important and should be practiced and standardized in the experimental laboratory. But boldness and manual dexterity in the human cannot be substituted for sound judgment, and sound judgment can only be acquired by knowing the natural course of the disease. The natural course of the disease does not manifest itself in the operating room or the laboratory and demands full attention from those who are caring for the total patient and not just part of him." He points out that in these times of

rapid technical advance fundamental principles remain and must ever remain as a home base, a foundation of basic facts which do not change even though their interpretation may have to be modified from time to time.

The book is divided into four parts dealing with (1) Fundamental Principles Affecting Vascular Surgery, (2) Methods of Diagnosis, (3) Vascular Syndromes Requiring Surgical Care, and (4) Surgical Technique.

**Treatment in Internal Medicine.** By Harold Thomas Hyman, M.D. Pp. 609. Price, \$12.50. Philadelphia, J. B. Lippincott Company, 1958.

The busy physician will find in this authoritative compendium of current treatment procedures a guide to the best that modern medicine has to offer in therapy. It is outstanding for its explicit presentation of technical knowledge and its combination of wisdom and common sense. The book is organized in 10 sections: The Infectious Diseases; Metabolic Disturbances; Neoplasms; Allergies, Collagen Disorders, Hypersensitivities, Idiosyncrasies and Untoward Reactions; Poisonings and Environmental Hazards; Disturbances of the Circulatory System; Disturbances of the Blood and Blood-Forming Organs; Neuropsychiatric Disturbances; Disturbances of the Endocrine Glands; and Disturbances in Specialty Fields. For most diseases or syndromes there is a review of background material and discussion of diagnostic criteria, followed by a description of today's most effective forms of therapy as recommended by leading authorities. Alternative suggestions are offered for variations in clinical reactions. Rosters of therapeutic agents, appearing appropriately at various points in the text, list drugs and medicinal products with objective comment on their relative advantages and disadvantages. This well organized, well written book offers a ready and reliable source of up-to-the minute information on the latest therapeutic and pharmaceutical advances.

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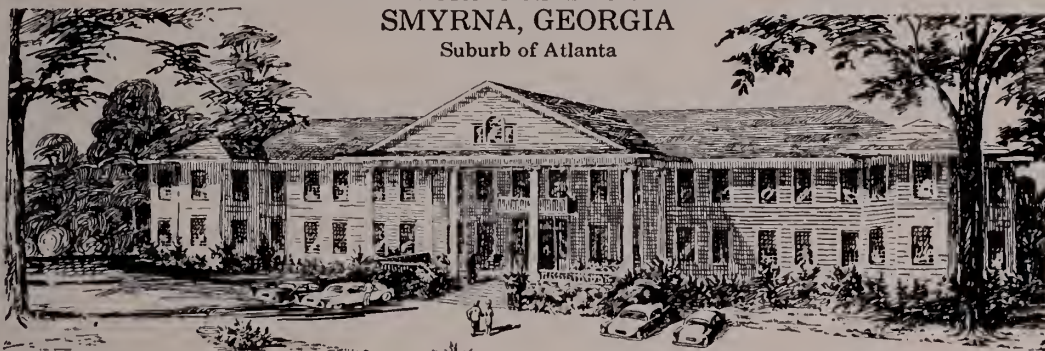
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ny of General Practice.....	Walter J. Glenn Jr., Ft. Lauderdale	A. MacKenzie Manson, Jacks'ville	Miami Bch., Oct. 29-Nov. 1
y Society.....	James H. Putman, Miami	Ben A. Johnson Jr., Jacksonville	Jacksonville, April 8-11, '60
esiologists, Soc. of.....	George C. Austin, Miami	George H. Mix, Lakeland	Miami Beach, Oct. 4, '59
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ric Society.....	B. A. Dobbins Jr., Ft. Lauderdale	Camillus S. L'Engle, Jacksonville	Jacksonville, Nov. 12-15, '59
& Reconstructive Surgery.....	Clifford C. Snyder, Miami	Bernard L.N. Morgan, Jacksonville	
logic Society.....	Don C. Robertson, Orlando	Matthew A. Larkin, Miami	
atric Society.....			
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Association.....	Sidney Davidson, Lake Worth	Mrs. E. D. Pearce, Miami	Miami, April 30, '60
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a, Medical Assn. of.....	Luther H. Wolff, Columbus, Ga.	Chris J. McLoughlin, Atlanta	Columbus, Ga., May 1-4, '60
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Hospital Conference.....	Oscar S. Hilliard, Ft. Oglethorpe, Ga.	Glenn Hogan, Atlanta	Miami Beach, May 3-7, '60
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astern Allergy Assn.....	C. P. Wofford, Johnson City, Tenn	Kath. B. MacInnis, Columbia, S.C.	
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
<b>Alachua</b>	George H. Putnam, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues	68
* <b>Bradford, Gilchrist, Union</b>				
<b>Bay</b>	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues	34
<b>Brevard</b>	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	67
<b>Broward</b>	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	242
<b>Collier</b>	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
<b>Columbia</b>	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* <b>Baker</b>				
<b>Dade</b>	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	960
<b>DeSoto-Hardee-Highlands-Glades</b>	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
<b>Duval</b>	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	359
* <b>Clay</b>				
<b>Escambia</b>	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	116
<b>Franklin-Gulf</b>	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
<b>Hillsborough</b>	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	242
<b>Indian River</b>	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	12
<b>Jackson-Calhoun</b>	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
<b>Lake</b>	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	36
* <b>Sumter</b>				
<b>Lee-Charlotte-Hendry</b>	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	43
<b>Leon-Gadsden-Liberty-</b>				
<b>Wakulla-Jefferson</b>	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	81
<b>Madison</b>	Thomas G. Boulard Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
<b>Manatee</b>	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	32
<b>Marion</b>	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	35
* <b>Levy</b>				
<b>Monroe</b>	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
<b>Nassau</b>	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	9
<b>Orange</b>	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	243
* <b>Osceola</b>				
<b>Palm Beach</b>	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	181
<b>Pasco-Hernando-Citrus</b>	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
<b>Pinellas</b>	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	309
<b>Polk</b>	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	133
<b>Putnam</b>	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
<b>St. Johns</b>	William J. Gibbon, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
<b>St. Lucie-Okeechobee-Martin</b>	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
<b>Sarasota</b>	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	93
<b>Seminole</b>	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
<b>Suwannee-Hamilton-Lafayette</b>	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
<b>Taylor</b>	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	6
* <b>Dixie</b>				
<b>Volusia</b>	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	101
* <b>Flagler</b>				
<b>Walton-Okaloosa-Santa-Rosa</b>	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	34
<b>Washington-Holmes</b>	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

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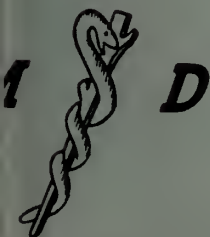
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1. Boland, E. W., and Headley, N. E.: Paper read before the  
Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc.,  
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• September, 1959

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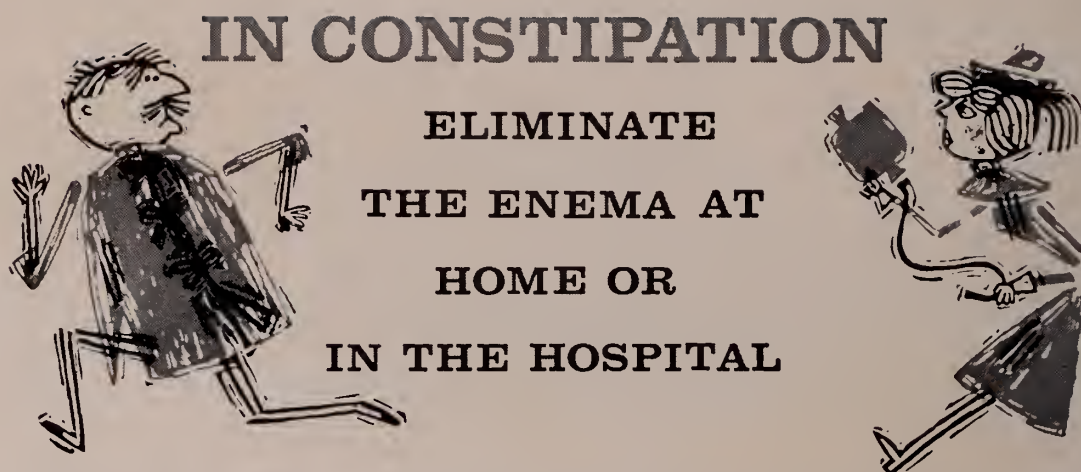
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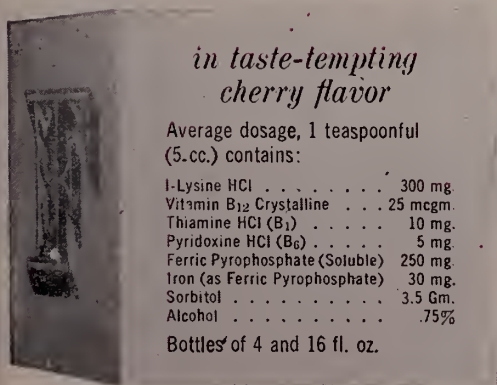
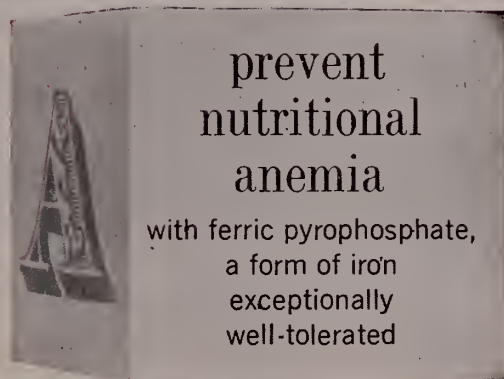
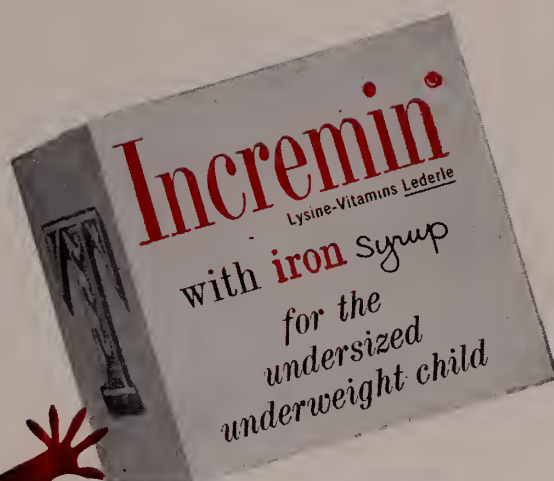
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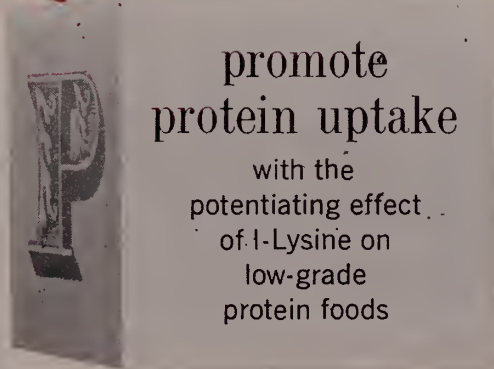


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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

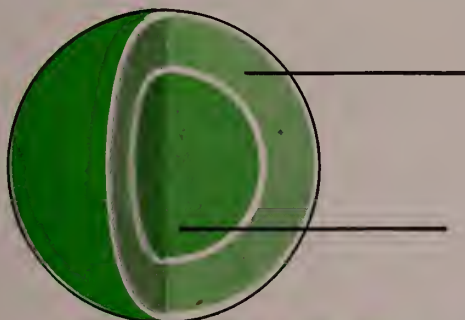




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*the formula: in the gastric-soluble outer layer:*

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Hyoscine hydrobromide .....	0.0033 mg.
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*in the enteric-coated core:*

Pancreatin, N. F. ....	300 mg.
Bile salts .....	150 mg.

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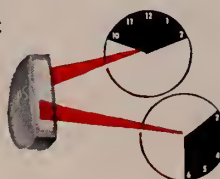
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- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

*safer and more effective than topical medication<sup>1,2,3</sup>*

- systemic transport to all respiratory membranes
- provides longer-lasting relief
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*Relief with Triaminic is prompt and prolonged because of this special timed-release action... beneficial effect starts in minutes, lasts for hours*



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Phenylpropanolamine HCl .....50 mg.  
Pheniramine maleate .....25 mg.  
Pyriminamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

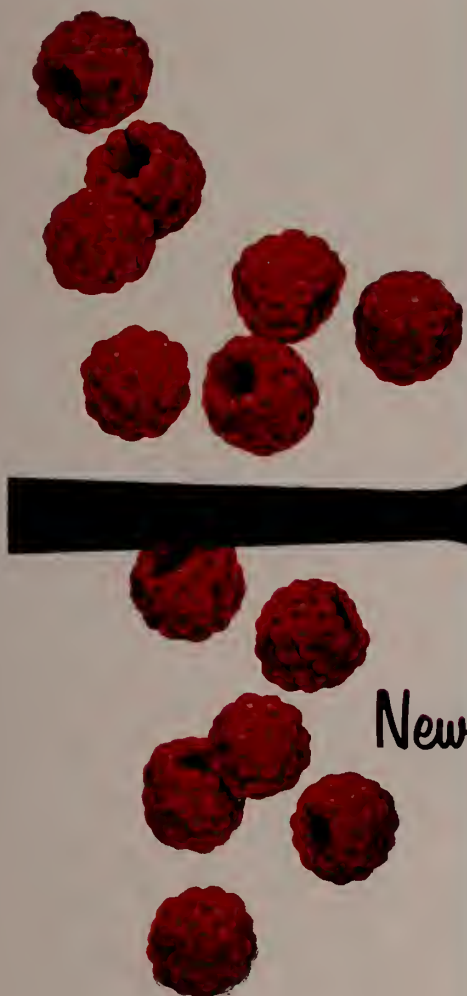
*Dosage:* One tablet in the morning, mid-afternoon and at bedtime.

*References:* 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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- Soothes inflamed mucosa
- Provides intestinal antiseptis

#### **DOSAGE:**

**ADULTS:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

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**Meclizine (12.5 mg.)**—the most effective anti-histaminic to control vestibular dysfunction.<sup>2</sup>

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Prescribe ANTIVERT for relief of Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

**Dosage:** One tablet before each meal.

**Supplied:** In bottles of 100 blue-and-white scored tablets. Prescription only.

**References:** 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.



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Regular aspirin crystals 24 hours after being mixed into water.

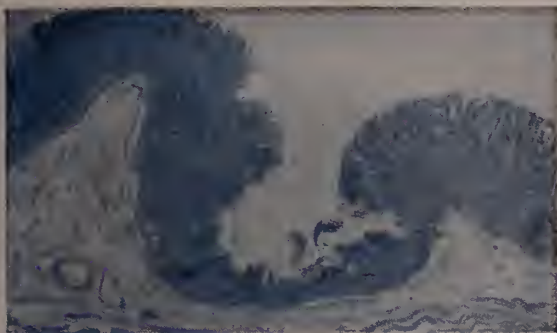


Calurin crystals in solution one minute after being mixed into water.

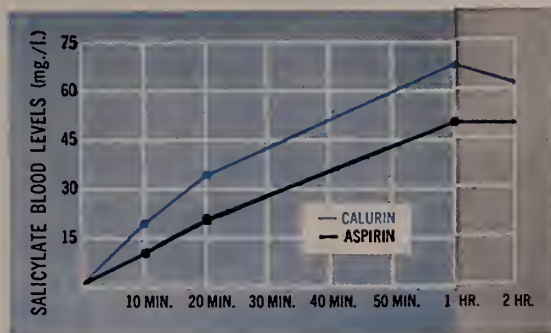


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**Particle-induced ulceration** — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
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- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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against ringworm

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Rapid clearing of tinea capitis, tinea barbae, tinea corporis, tinea cruris, tinea pedis and onychomycosis caused by *Microsporum*, *Trichophyton* and *Epidermophyton* organisms.

**Packaging:** FULVICIN is supplied as 250 mg. scored tablets, bottles of 30.

**Bibliography:** (1) Riehl, G.: Griseofulvin: An Orally Active Antibiotic, presented at Austrian Dermat. Soc. Meet., Vienna, Nov. 27, 1958. (2) Williams, D. I.; Marten, R. H., and Sarkany, I.: *Lancet* 2:1212, 1958. (3) Blank, H., and Roth, F. J., Jr.: *A.M.A. Arch. Dermat.* 79:259, 1959. (4) Goldfarb, N., and Rosenthal, S. A.: *Current M. Digest* 26:67, 1959. (5) Reiss, F.: *Medical Circle Bulletin* 6:9, 1959. (6) Robinson, H. M., Jr.; Robinson, R. C. V.; Bereston, E. S.; Manchey, L. L., and Bell, F. K.: Griseofulvin, Clinical and Experimental Studies, presented at Am. Dermat. Assoc. Meet., Atlantic City, N. J., June 3, 1959.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 3, September, 1959

## Polio-Like Diseases in South Florida

M. M. SIGEL, PH.D., M. J. TAKOS, M.D.,† G. G. SCHLAEPFER, B.A.,  
M. C. LAUNER AND R. V. CATING, R.N.

MIAMI

Ten years ago, the Virus Diagnostic Laboratory was successful in determining the exact cause of illness in approximately 20 per cent of patients with aseptic meningitis. At the Virus Diagnostic Laboratory at Children's Hospital in Philadelphia, one of the authors obtained positive results from 34 of 155 patients tested by serologic procedures.<sup>1</sup>

By contrast, nine years later the Virus Diagnostic Laboratory at Variety Children's Hospital and the University of Miami School of Medicine obtained 93 positive results in 165 patients (56 per cent) with meningitis, polio and polio-like diseases (table 1). The advent of tissue culture and the application of this technic for the diagnosis of viral diseases have increased the efficiency of the laboratory by over two and a half fold. While the serologic test is still much in use and provides a relatively simple and inexpensive diagnostic tool, by and large many of the answers to illnesses resembling polio have come from the utilization of tissue culture.

Although cultivation of cells and tissues *in vitro* has been practiced on a limited scale for over 30 years, the development and growth of applied tissue culture for diagnosis and epidemiologic study is young. It was exactly 10 years ago that Enders, Weller and Robbins<sup>2</sup> first discovered that poliomyelitis virus could multiply in tissue culture. This discovery, which rightly earned the Nobel Prize, was to lead to the subsequent development of a vaccine against poliomyelitis as well as to the large scale application in the diagnosis of polio and polio-like diseases. Tissue culture has been responsible for the recognition of a large number of heretofore unknown agents inhabiting the intestinal tract, and a number of

these are now being associated with illnesses resembling polio. Many of these viruses have been generally classified as ECHO viruses, or Enteric Cytopathogenic Human Orphan viruses. The name "Orphan" implies their lack of affiliation with specific disease, but, as will be discussed later, the term may no longer be applicable to several of these agents.

The physician is becoming aware of the existence of viruses belonging to the ECHO category. He often is puzzled as to their significance and sometimes considers them as laboratory curiosities. Certainly, the name justifies such an opinion. Be that as it may, the ECHO viruses and the somewhat earlier discovered group of Coxsackie viruses which emerged into prominence following the classical work of Dalldorf and Sickles<sup>3</sup> are becoming recognized. Increasing clinical importance is being attached to them with each succeeding year and with the development of better tests and the establishment of more laboratories.

Among the 165 patients being discussed today, 35 were hospitalized with various degrees of paralysis. Among the 35 patients, 29 yielded virus, as shown in table 2. Thus a total of 82 per cent of paralytic patients had some virus present in their stool. Twenty had Polio Type 1 virus, eight had Polio Type III virus, and one yielded Coxsackie B<sub>1</sub> virus. It is likely that the B<sub>1</sub> Coxsackie virus was merely an innocent bystander in this particular illness, as we did not obtain serologic confirmation to implicate this virus as a possible cause of the paralysis.

Table 3 shows the breakdown of findings in patients suspected of having viral aseptic meningitis. Among 130 patients, 64 had virus in their stool or spinal fluid. This is a frequency of 49 per cent. Thus, in contrast to patients with paralysis, among whom 82 per cent had a virus

†Deceased

From the University of Miami School of Medicine, Dade County Health Department and Virus Diagnostic Laboratory, Variety Children's Hospital, Miami, Fla.

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

**Table 1.—Comparison of Effectiveness of Serologic and Tissue Culture Test Procedures**

Year	Type of Test	Number of Patients Tested	Number Positive	Per Cent Positive
1949	Serologic	155	34	22
1958	Virus isolation in tissue culture	165	93	56

**Table 2.—Virus Isolations From Patients With Suspected Paralytic Polio**

Number Tested	Virus Isolated			Total Isolations	Per Cent Isolations
	Type I	Type III	Coxsackie B <sub>1</sub>		
35	20	8	1	29	82

**Table 3.—Virus Isolations From Aseptic Meningitis; 130 Patients**

Virus Isolated	Number of Isolations
Polio Type I	7
Polio Type III	3
Coxsackie B <sub>2</sub>	3
Coxsackie B <sub>4</sub>	2
Coxsackie B <sub>5</sub>	6
Coxsackie A <sub>0</sub>	4
ECHO-4	16
ECHO-9	14
Other ECHO's, misc.	9
Total	64 (49%)

**Table 4.—Relationship of 29 Poliovirus Isolations From Paralytic Patients to Previous Polio Immunization**

Virus Type	Number of Injections of Antipolio Vaccine				
	0	1	2	3	Unknown
Type I	18	2	0	0	0
Type III	7	0	0	2	0
Total	25	2	0	2	0
Per cent based on 29 positive isolations	86	7	0	7	0
Per cent based on all paralytic patients (35)	71	6	0	6	0

present, a large proportion of the patients with meningoencephalitis did not yield a known virus. It is, therefore, possible that other causes, so far unknown, may be responsible for about 50 per cent of the cases of aseptic meningitis. It should be pointed out, however, that failure to isolate the virus did not rule out possible infection with a given agent. As confirmation of this observation, serologic results with some of the patients indicated that viruses of the Coxsackie group and mumps virus were associated with some of the illnesses in patients from whom virus could not be isolated. If we were to include serologic results along with the virus isolation findings, the positive results would be increased to 58 per cent.

An important conclusion which may be drawn from table 3 is that poliovirus accounted for a small percentage of patients with aseptic meningitis. The highest percentage of patients had the viruses of ECHO-4, ECHO-9 and other types of ECHO viruses.

The question is raised as to the frequency of infection with polio and with related viruses in persons who have received antipolio vaccines. The findings in paralytic patients relating to this point are shown in table 4. It may be seen that 25 of the 29 paralytic patients from whom poliovirus was isolated received no polio vaccination. Two patients yielding virus had one shot of vaccine, and two patients had three inoculations of vaccine. These results indicate that a majority of paralytic patients from whom poliovirus could be isolated were in the nonvaccinated group. Results of virus isolations from nonparalytic patients as related to polio immunization are shown in table 5. It is seen that immunization is without effect on the incidence of isolation of enteric viruses other than polio from such patients.

The breakdown of positive results by month of illness is shown in table 6. It is rather interesting to note that poliovirus was found in relatively high percentages of polio and polio-like illnesses during January, November and December, in spite of the relatively small number of specimens submitted during these months. On the other hand, other viruses appeared to predominate during the months of June, July, August and September. It was during these months that both the medical profession and the press were concerned over the high increase in so-called poliomyelitis. It is, therefore, not surprising to find that large numbers of specimens were submitted for examination. Yet, in spite of the large number of specimens, there was little polio, and the high predomi-



Table 5.—Relationship of Virus Isolations From Nonparalytic Patients to Previous Polio Immunization

Virus Isolation	Number of Injections of Antipolio Vaccine					Total
	0	1	2	3	Unk'n	
Polio	5	1	1		3	10
Coxsackie A				4		4
Coxsackie B	4	1		5	1	11
ECHO-4	4	1	5	3	3	16
ECHO-9	3		3	6	2	14
ECHO's-other	2	1	3	1	2	9
Negative	20	7	11	21	7	66
Total	38	11	23	40	18	130
Per cent positive for poliovirus	13	9	4	0	17	8
Per cent positive for other enterovirus	34	27	48	48	44	42

nance was among the Coxsackie and Echo viruses. It may be of interest that ECHO-9 virus, which clinically was associated with illnesses characterized by rash, meningitis, or rash with meningitis, first made its appearance in our locality in May and persisted throughout September; ECHO-4 appeared somewhat later and was still with us in October.

During the month of May, when only one case of polio-like illness yielded ECHO-9 virus, this virus was responsible for a small localized outbreak of a clinical entity characterized by a peculiar rash. This outbreak will be discussed separately at another opportunity.

The distribution of positive virus isolations from different sources is given in table 7. It may be seen that 87 stools were positive for virus; 14 spinal fluids were positive; and viruses were isolated in eight instances from both stool and spinal fluid. It is noteworthy that, whereas all types of viruses could be demonstrated in the stools, the spinal fluids yielded only ECHO and Coxsackie viruses, a fact in keeping with the previously known information about the rarity of poliovirus isolation from the spinal fluid.

Table 6.—Frequency of Virus Isolations From Polio and Polio-Like Diseases in 1958

Month	Number of Specimens	Virus Isolations									Negative
		Poliovirus		Coxsackie				ECHO			
		I	III	A <sub>9</sub>	B <sub>2</sub>	B <sub>4</sub>	B <sub>5</sub>	4	9	Other	
January	3	2									1
February	2										2
March	5		2								3
April	2		1								1
May	7	2	1						1	2	1
June	16	4		1	1			1	3	2	4
July	44		2	1		2	1	7	4	1	26
August	38	3	2		2		3	3	5	2	18
September	27	4	3	2			2	4	1	1	10
October	5		1					1			3
November	7	4								1	2
December	9	8									1
Total	165	27	12	4	3	2	6	16	14	9	72

Table 7.—Sources of Positive Virus Isolations

Virus	Source of Virus Isolation			Total
	Stool	Spinal Fluid	Stool and Spinal Fluid	
Polio I	27			27
Polio III	11			11
Coxsackie A <sub>0</sub>	4	2	2	8
Coxsackie B <sub>1</sub>	1			1
Coxsackie B <sub>2</sub>	3			3
Coxsackie B <sub>4</sub>	2			2
Coxsackie B <sub>5</sub>	5	1		6
ECHO-4	14	4	2	20
ECHO-9	11	7	4	22
ECHO's-other	9			9
Total	87	14	8	109

During the year, there were many patients seen by physicians and also admitted to the hospital who presented clinical pictures consistent with a diagnosis of nonparalytic polio or aseptic meningitis. As illustrated by the three case histories presented herein, it was difficult if not impossible to ascertain clinically which of the particular viruses of the enteric group—polio, Coxsackie or ECHO—may have been associated with the particular clinical picture. It is in this particular area that the Virus Diagnostic Laboratory provides the greatest service to the practicing physician. No one can question the value of the laboratory to the public health officer or to the community at large or to research, but the type of findings presented today illustrates that even the clinician may derive benefit from the tests performed in the virus laboratory. The findings accentuate the value of polio vaccination. Furthermore, they increase the knowledge about the existence of agents capable of producing illness mimicking in many respects some type of poliomyelitis.

Finally, they have brought about greater realization as to the continued need for research and clinical and virologic investigation on the causation of diseases of the central nervous system and the possible importance of agents inhabiting the gastrointestinal tract as causes of such illnesses.

Report of Cases

Case 1.—A 16 year old white female  
Date of admission: 9/14/58

History:  
Headache for four days; chills and fever for two days. Nausea and vomiting, with fever, on date of admission. Pain in left side of chest. No polio immunization.

Physical findings:  
Head and neck: severe stiffness of neck, otherwise negative  
EENT: Not remarkable  
Heart: Tachycardia, no murmurs  
Chest and lungs: Chest symmetric; lungs clear, breath sounds normal, no rales  
Abdomen: Soft, no tenderness, no mass or rigidity  
Lymphatics: Negative  
Neurologic: Stiff neck, positive Kernig's sign, no weakness  
Extremities: Negative  
Impression: Aseptic meningitis

Laboratory findings:  
Spinal fluid: 9/14/58 590 WBC Sugar 72 mg.%  
(cloudy) 14% polys Protein 58 mg.%  
86% lymphs Pandy: not increased

Blood: 9/14/58  
10,500 WBC  
65 segs  
31 lymphs  
2 stabs

Coxsackie B-5 virus isolated

Case 2.—A 5 year old Negro male  
Date of admission: 8/20/53

History:  
Patient in good health until three days before admission; then developed headache, fever and nose pain. No vomiting, diarrhea or cough. Rash on face for one week. One polio vaccination, five days prior to admission.

Physical findings:  
EENT: Injected and hypertrophied inferior nasal turbinates  
Skin: Rash on face, warm and dry  
Lungs: Clear to P and A  
Heart: No murmurs  
Neck: Stiff, positive Kernig's sign  
Abdomen: Negative  
Neurologic: Normal  
Genitalia: Normal male  
Back: Back muscles stiff

Impression: Aseptic meningitis

Laboratory findings:  
Spinal fluid: 8/20/58  
Culture negative for bacteria  
20 WBC Sugar 64 mg.%  
15% polys Protein 25 mg.%  
85% lymphs Chlorides 126 mg.%  
Pandy: not increased

Blood: 8/20/58  
5,650 WBC  
30 lymphs  
67 segs  
2 stabs  
1 eosin

Poliovirus type I isolated

Case 3.—A 15 year old white male  
Date of admission: 8/20/58

History:  
Headache for three days, stiff neck for two days. Fever to 102 F. orally. Difficulty in talking, voice changes noted by mother. Sore throat, vomiting and fever. No polio immunization.

Physical findings:  
Marked stiff neck  
No muscle weakness  
Hamstring tightness

Impression: Aseptic meningitis  
Laboratory findings:  
Spinal fluid: 8/20/58  
(cloudy)  
Culture negative for bacteria  
1,558 WBC      Sugar 72 mg.%  
75% lymphs    Protein 86 mg.%  
25% polys      Pandys: increased  
  
8/23/58  
(bloody)  
Culture negative for bacteria  
19 WBC      Protein 107 mg.  
60% lymphs    % (centrifuged)  
40% polys  
  
Blood: 8/21/58  
7,400 WBC  
46 lymphs  
45 segs  
2 monos  
4 stabs  
2 eosin  
1 baso

ECHO-9 virus isolated

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Variety Children's Hospital

Discussion

NATHAN J. SCHNEIDER, PH.D., M.P.H., JACKSONVILLE, DIRECTOR, BUREAU OF LABORATORIES, FLORIDA STATE BOARD OF HEALTH: The data presented by Dr. Sigel this morning emphasize the need for physicians to be aware of the large number of viral agents associated with polio-like diseases. Definitive diagnosis of the etiology of such diseases, particularly in cases of nonparalytic polio or aseptic meningitis, requires assistance from the virus laboratory. The establishment of the etiologic agent involved, while not generally required for therapy, is useful to the clinician from an epidemiologic point of view. Such vital data are also required in maintaining adequate poliomyelitis surveillance and in evaluating the effectiveness of the Salk vaccine immunization program.

In Florida, there are two viral diagnostic laboratory facilities available to the practicing physician and to local health departments; the one mentioned by Dr. Sigel in his presentation this morning serves the Variety Children's Hospital and the Dade County area. The other laboratory is located in Jacksonville as part of the Bureau of Laboratories of the Florida State Board of Health. Its services are available to physicians within the state of Florida. Appropriate specimens properly frozen and packaged should be shipped via air express to reach the state laboratory as quickly as possible. Experience during the past several years has indicated the feasibility of providing viral diagnostic service from a distant laboratory. Unless, however, such specimens reach the laboratory in proper condition to insure that the virus, if present, is viable, there is little value in attempting costly viral isolation studies.

With your permission, I would like to show two tables which will permit a comparison of the experience of polio-like diseases on a statewide basis with that which occurred in South Florida.

In table 1, there are presented the findings obtained in the State Virus Diagnostic Laboratory on 579 patients with central nervous system symptoms during 1958. A positive diagnostic laboratory finding was obtained in 253 or 43.7 per cent of these patients. You will note that etiologic agents listed on the chart include lymphocytic

Table 1.—Laboratory Findings\* on 579 Patients Manifesting Central Nervous System Symptoms

Etiologic Agent	Positive	Negative
LCM	1	396
Mumps	20	392
EEE	1	395
WEE	0	172
SLE	0	396
Polio type 1	102	399
Polio type 2	10	491
Polio type 3	16	485
ECHO type 4	2	
ECHO type 9	59	440
Coxsackie type A <sub>o</sub>	8	
Coxsackie type B <sub>a</sub>	2	
Coxsackie type B <sub>i</sub>	2	
Coxsackie type B <sub>s</sub>	18	481
Leptospirosis	12	291

Total Positives 253 (43.7 per cent)

\* Performed during 1958.

choriomeningitis (LCM), mumps, the arthropod-borne encephalitis viruses and leptospirosis, in addition to the enteroviruses considered by Dr. Sigel. The importance of including these additional agents is apparent when you note that there was laboratory evidence of 20 cases of mumps and one case each of lymphocytic choriomeningitis and eastern equine encephalitis. Also 12 cases of leptospirosis were determined serologically on paired acute and convalescent phase serums from patients with an aseptic meningitis syndrome. In all of these cases, viral etiology had been suspected by the clinician.

Our experience with the enteroviruses in 1958 was similar to that reported by Dr. Sigel. There were 128 patients whose reactions to tests were positive for polio; 61 were infected with ECHO and 30 with Coxsackie viruses. A large number of ECHO-9 agents were found in patients from the Northeast Florida area during the early spring and from the Polk County area during the summer. Also in Polk County, we encountered a wide variety of all of the enteroviruses, including type 1 and an occasional type 3 polio virus. Coxsackie agents were found statewide.

In table 2, data are presented to compare two serologic tests for polio, the neutralization and the complement fixation procedures. All patients in this study had been found to be infected with a polio virus as proved by isolation of the virus in the stool at the time of illness. One, therefore, might expect a reasonably high percentage of serologic confirmation of the infection. Yet, by the neutralization test, in only 45.8 per cent of the paralytic cases were there positive reactions serologically as compared to 22.6 per cent in aseptic meningitis cases. A somewhat better confirmation of infection was obtained with the complement fixation test, 62.5 per cent positive reactions among the paralytic cases as compared to 18.4 per cent among the nonparalytic cases. Although the numbers of patients in the study were small, there is suggestive evidence that the complement fixation test is



Table 2.—Comparison of Effectiveness of Polio Serologic Tests on Patients From Whom Polio Virus Was Isolated

Clinical Status	Neutralization (1957*)			Complement Fixation (1958*)		
	Positive**		Negative†	Positive**		Negative†
	No.	Per Cent		No.	Per Cent	
Paralytic	11	45.8	13	10	62.5	6
Aseptic meningitis (nonparalytic)	7	22.6	24	9	18.4	40

\* Two separate groups of patients.  
\*\* Significant rise in titers of paired serums against homotypic strain.  
† Absence of significant rise.

preferable to the neutralization test from a diagnostic point of view. More importantly, it must be emphasized that one should not depend on serologic tests alone in polio laboratory diagnostic work. Stool specimens should be examined for enteroviruses as part of an adequate laboratory study of polio-like diseases. You, therefore,

can appreciate why we in the laboratory need both stool and blood specimens on the patient to determine the etiologic cause of the illness.  
Finally, I would like to commend Dr. Sigel for an excellent and timely presentation and to thank you for the opportunity to discuss his paper.

# The Juvenile Amputee

## *Preliminary Report of the Problem in Florida*

NEWTON C. McCOLLOUGH, M.D.

ORLANDO

The juvenile amputee can be defined as any amputee under 16 years of age. At this point in age there is a division of many of the individual reactions to the problem of amputation, both psychologically and physically, which permits two fairly definite groupings, the adult and the juvenile amputee.

Surgical indications as to the level of amputation vary widely in both categories, as do prosthetic prescription, fitting and training. Clarification for all concerned is indicated, especially in the light of new conceptions as to management and recent prosthetic developments.

In 1955 the prosthetic division of The National Research Council, realizing the divergence of the juvenile and adult amputee groups in prosthetic fitting and training and the importance of the child amputee in the crippled children's population, organized the Committee on Child Prosthetics Problems, headed by Charles H. Frantz, M.D., as an advisory group to the Committee on Prosthetic Research and Development. The research and development of children's appliances

at the Army Prosthetic Research Laboratory at Walter Reed Medical Center in Washington, D. C., has produced devices allowing a greater latitude in the fabrication of prostheses than ever before known. Dr. Frantz and Dr. George T. Aitken, of Grand Rapids, Mich., under the auspices of the Michigan Crippled Children's Commission, Carlton Dean, Director, have done pioneer work in the field and have developed since 1949 at Mary Free Bed Hospital a clinic and research center of now international authority. The Prosthetic Division of the National Research Council, with the aid of the Veterans Administration, has established training schools at New York University and the University of California, at Los Angeles, to educate surgeons, prosthetists, physical therapists and occupational therapists as to proper fitting, training and management of the amputee. This step has been essential in the light of the brilliant prosthetic engineering advances of the University of California, at Berkeley and Los Angeles, and the painstaking field testing and evaluation of new devices at

New York University. Many of these appliances are still, and will be in the future, of necessity tested by carefully selected participating clinics throughout the United States, before their manufacture and sale to the public will be permitted.

The team approach, fostered by both training schools, to the juvenile and adult amputee has been widely taught and accepted as achieving the highest degree of service for the patient. The team consists of a surgeon, the prosthetist, physical therapist and medical social worker, or for the adult a Vocational Rehabilitation worker. The provision of a psychologist is a valuable addition to the team. All members have special knowledge in their fields and by open discussion prescribe and fit the proper prosthesis and issue proper training and guidance. The surgeon is the captain and coordinator of the team, which provides:

1. Examination and evaluation of the child amputee.
2. Preprosthetic corrective physical and occupational therapy, when needed.
3. Fabrication and fitting of a prosthesis.
4. Postfitting, inpatient training period and controlled recreational activities.
5. Outpatient follow-up clinics, requiring a minimum of four visits annually, to correct mechanical defects from wear and tear, breakage or component failures.

The ever increasing growth of the child requires periodic lengthening and/or socket enlargement to accommodate for increase in muscle mass and variation in height and weight.<sup>1</sup>

The juvenile amputee has tremendous emotional adjustments as his personality develops, which are complicated and augmented frequently by parental nonacceptance of the child's predicament and prosthetic therapy. "It is a peculiar phenomenon of psychology that the recommendation for a lower extremity prosthesis is readily acceptable, but contrarily, there is at times a tendency to reject an upper extremity prosthesis. This phenomenon usually pertains to girls with the reluctance exhibited by the mother. In the congenital group the refusal may be nurtured by deep roots of guilt activated by fear of a hereditary taint. In the traumatic group the guilt often springs from a deep feeling of negligence in reference to the episode causing the accident. Both these basic reactions manifest themselves and may convey the impression of a blind reluctance to accept the presence of a functional disability. An excuse not unusual is the revulsion to the cosmetic appearance of the terminal hook. It is understand-

able that such feeling on the part of the parents can be readily transferred to the child."<sup>2</sup> This attitude by the parents often spells defeat in proper fitting and training in spite of an intelligent and cooperative effort on the part of the patient. It follows that careful parental approach and education are as important in reaching the goal of a good functional juvenile prosthetic wearer as are the prescription and the fitting of the prosthesis and the training that follows.

The physical aspects vary greatly from those of the adult amputee. There is rarely a phantom limb in traumatic amputees under 10 years of age and it is never present in the congenital group. The healing of skin and other soft tissues occurs more readily and scars are soft, pliable and usually painless. Neuromas are, of course, present, but uncommonly are symptomatic, requiring surgical removal of nerve end transplant. The level of amputation in the lower extremity is not as important as in the adult. Very short, or very long, BK (below knee) stumps can be fitted and motivated satisfactorily. Disarticulation to save the distal epiphysis at knee or ankle may provide, in addition to a continuance of growth, a satisfactory end-bearing stump. Midfoot and forefoot levels and even the preservation of only the talus and os calcis can be acceptable. Split grafts may be used to replace skin and subcutaneous tissue where lost and mature to the point they make excellent wearing stump coverage. In the upper extremity the same rule used in treating the adult still applies; never sacrifice a millimeter of bone unnecessarily.

Bone in the surgical or traumatic juvenile amputee under 10 years of age outstrips the growth of the soft tissues. Thus one finds increasing tension at stump tip with occasional bursa formation necessitating removal of bone at intervals. The scar of a fishmouth closure of an above knee stump may migrate proximally on the posterior surface 3 to 4 inches as bone growth stretches the anterior flap downward. This overgrowth does not appear in the congenital amputee or in disarticulation. The bone of the stump following the Wolffian law will curve in the direction of force applied. In the below knee stump the tibia exhibits a varus and kyphosis, and in the humerus a varus curve appears.<sup>3</sup>

The crutches and the empty sleeves found in child amputees in the past until they were old enough to "handle a prosthesis" are now disappearing from the American scene. The cerebral development which motivates creeping, walking

and bimanual dexterities occurs at the same age in the juvenile amputee as in the normal child. It follows that prostheses could be applied in the upper extremity at five to six months and in the lower extremity at 10 to 18 months, the ages at which these developments appear. The upper extremity juvenile amputee has in the past five years been fitted at a progressively earlier age, essentially for the following reasons:<sup>4</sup>

1. To promote the development of a functional pattern involving both hands in the congenital amputee.
2. To mask the sense-organ function of the stump or deficient limb.
3. To prevent abnormalities and asymmetries of posture that are secondary to the substitution patterns of the young upper extremity amputee.
4. To develop prosthetic tolerance and acceptance as early in life as possible.<sup>4</sup>

In large numbers of the very young upper extremity amputee group the passive mitt is applicable and at six to 12 months permits bimanual handling of the bottle and large toys, and creeping. Bilateral amputees respond equally as well as unilateral amputees, and both groups early learn to regard the prosthesis as part of themselves, even crying when it is removed. It is important after fitting never to deprive the child of the prosthesis for any long period of time as he will again begin to use the stump for tactile sense. Repairs and fittings should be within a period of a few days, if possible. At 24 to 36 months a terminal device may be added and further training given. The unfitted unilateral upper extremity amputee uses his stump as an assistant to his normal extremity, and the shortness of the stump forces him to carry out all bimanual activity close to his trunk, which may also be used as an additional aid. This continuous maneuver results in a lack of development of the cerebral cortex in areas controlling bimanual activity at arms length from the trunk. Early fitting, at ages six months to one year, with the passive mitt provides extremities of equal length and permits normal development of these cortical areas. Thus, the late fitted juvenile amputee never attains the skill in arm length activities found in those who had a prosthesis applied early in life.

Patients with congenitally short femurs (phocomelia), absence of the fibula and many other upper and lower extremity abnormalities can be considered to be congenital amputees. Surgical conversion of these abnormalities to conven-

tional stumps at an early age should be avoided whenever possible even though they necessitate bizarre and unsightly prostheses. Cosmesis is not an important issue for a patient in this age group. The epiphyseal growth is not interrupted, and prolonged observation will lead to a better decision regarding the type and level of the surgical amputation in the congenital amputee.

The parents, who are carrying the emotional burden of this deformity in length in their child's extremity, immediately and vociferously reject any initial suggestion that any portion of it be removed. Their resentment at such a suggestion at first visit may lose permanently for the surgeon the rapport so vital between him and the family, their confidence, and even their future attendance at the clinic.

Under the care of the Florida Crippled Children's Commission, William Stinger, M.D., Director, there are now 107 amputees 16 years of age or under. The following breakdown reveals some interesting points:

#### Congenital Amputees

Congenital	Upper	Lower	Quadruple	Total
63%	32%	34%	1%	67

Of these 67 congenital amputees 19 have been converted to stumps more readily treated prosthetically and doubtless in the future more of the remainder will be managed in this manner.

#### Surgical and Post-traumatic Amputees (37 Per Cent)

	Post-traumatic	Tumor	Infection	Snakebite	Total
Upper	7	0	1	2	
Lower	19	4	2	5	
	26 or 65%	4 or 10%	3 or 7%	7 or 17%	40

The proportion of congenital amputees to surgical and post-traumatic amputees is slightly higher than that found in most clinics. It is noteworthy here that Frantz and Aitken<sup>2</sup> reported 64 per cent of all congenital upper extremity amputees fall into a short, below elbow group in which two thirds of the deformities are on the left side.

In an amazingly high percentage of the surgical or post-traumatic group (17 per cent), the amputation was due to snakebite. This must not lead one to a definite conclusion in this matter, as the series is too small to avoid coincidence as a factor, but the figure is high enough to bring to mind perhaps some effort at control in the future. Any further study will include an analysis of the type



of snake involved and treatment rendered. The cottonmouth moccasin and the diamondback rattlesnake without question are the major offenders.

One cannot assume this is the total of juvenile amputees in this state as many are undoubtedly under the care of other agencies or private physicians, but it is logical to assume that this is by far the major group under treatment.

As the population of Florida continues to grow, its birth rate, its traffic and traffic accidents will bring a proportionate increase in juvenile am-

putees. Members of the medical profession of Florida must be cognizant of the problem to the extent that they can meet it with the knowledge and skill they have applied to other surgical and social problems in the past.

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## The Physician and Community Mental Health

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Of recent years physicians have become increasingly aware of two "new" health problems in our communities, the increasing problems in geriatrics and the unsolved riddles of mental disease. Each of these constitutes a tremendous challenge. Most medical practitioners have made some progress with their handling of geriatric problems, but here, even the teachers of medicine differ on the special importance of geriatrics. There has been some improvement likewise in the handling of mental illness problems.

What we as physicians read in professional journals concerning mental disease is often confusing to most of us. The psychiatrists do not always use a language meaningful to us in our daily practice. They most often emphasize the psychotic patients, while the average practitioners see the maladjusted, the troubled, the mentally deficient, or the prepsychotic patient. It can be comfortable for us to say to ourselves, "I don't think I should work with mental patients since I've had no special training in this field. Whenever those research boys dig up something concrete for me to do, then I'll work with these patients more."

With this type of thought most of us sit back, satisfied that we have done all that is possible in view of today's knowledge. This attitude is prevalent among many of the physicians of our state. This attitude is particularly undesirable among physicians, who should be serving as

leaders of their communities in mental as well as physical health matters.

It is hard to visualize just where medicine would be today if our predecessors had waited for a complete blueprint for solution of a health problem before beginning to attack that problem. Think of Dr. John Snow, who had the Broad Street Well in London closed in 1854 because he thought, on the basis of epidemiologic evidence, that the water from this well was responsible for the spread of cholera in the neighborhood. At that time few had ever heard of bacteria; the etiology of cholera had not been established; and no case of transmission of disease with water as the vehicle had ever been shown. Yet he developed conclusions from his observations and he acted. He could hardly have done better today, with our hundred years of additional knowledge.

We know enough today about the natural history of mental disease to make some conclusions and take some action. As physicians we have this responsibility to our communities. We know enough of the natural history of mental disease to recognize many places where we might erect barriers to the development of mental disease.

We know the hereditary history of Huntington's chorea, the attack rate of 50 per cent, the average age of onset and the fact that no environmental factors can affect the outcome. We know that the incidence of schizophrenia is higher when one or both of the parents are schizophrenic, that the attack rate is 16 per cent when one

parent is schizophrenic, and that it is 68 per cent when both parents are. Compare these figures with the incidence in the general population of approximately 0.0005 per cent. We know with fair certainty some of the social, economic and environmental factors that seem to be important in the development of mental disorders and social maladjustments.

A large portion of the barriers that we can erect to impede or prevent the development of mental disabilities lies in the field of community action. Of recent years many medical societies have become known in their communities as a group that is ultraconservative, and not as a group that is known for its active community leadership. Too few individual doctors are active community leaders. Too many of our medical societies exhibit a desire not to take sides in community projects.

There is a growing interest among citizens of this nation on matters of health and welfare. The many nonprofit associations concerned with health matters attest to this. These organizations are playing a vital part in our conquest of illness and its associated problems. If the physicians of Florida would contribute their special knowledge and take more active roles in these organizations, I believe that better planning would result among these health groups, and our communities, patients and profession would be better served.

Members of the medical association should enter wholeheartedly into the community planning. Maybe in some cases physicians will work in directions that are later found not to be the ideal. I do not think that it speaks ill for a man, or a group, to make a mistake while making an honest effort.

One American physician is actually well known today for the many honest mistakes he made throughout his life, in his earnest efforts to serve his fellow man in his community. Many of his conclusions have been proved to be inaccurate, but Dr. Benjamin Rush is still considered one of the greatest men produced by American medicine.

We as physicians, as individual citizens, and as a group can help attack the community problem of mental illness in our offices, through our local societies and through community groups, with the realization that mental disease like physical disease has a natural history, treatment and prognosis.

Mental disease and disability should be looked at through optimistic colored glasses, never with the attitude that it is there, and there is not much I can do about it. Instead, I should ask myself, "What shall I do now to help protect my patient from further ravages of this condition?"

Dr. Hugh Leavell of Harvard University recommends planning for the prevention and control of disease by applying his "Levels of Prevention."

1. **HEALTH PROMOTION**—includes education for good health, avoidance of disease exposures, healthful environment and others.
2. **SPECIFIC PROTECTION**—prophylactic treatment, immunizations, preventive examinations and others.
3. **EARLY DIAGNOSIS AND TREATMENT**—routine examinations, and investigation of contacts.
4. **LIMITATION OF DISABILITY**—doing all possible to arrest a disease process, case finding work for latent cases, and prompt treatment.
5. **REHABILITATION**—after applying levels 1 to 4, and if the patient still experiences disability, efforts aimed at rehabilitation are then stressed.

There should be probably another level of prevention—Basic Research—to further our knowledge.

These six represent points of attack common to most disease processes, and they make a most useful framework within which we can plan the attack on mental disease in our community.

#### **Level 1—Health Promotion**

We teach our patients to eat a balanced diet, to take moderate exercise, and to get plenty of rest, thereby promoting maximum physical health. During youth when the many factors that result in a happy, well adjusted life react upon the young human, we should realize that helping our young to obtain understanding and sympathetic parents, adequate recreation facilities, good schools, and many other social resources offers a fertile community field for our activities. These are some of the areas where we can work to promote good community mental health and build some barriers to the development of mental dis-

ease. These are factors in good mental health promotion.

General emotional mental health promotion is prevention of mental illness. Helping young parents understand themselves and the problems of growth and development of their children leads to an improved emotional environment for the next generation and thus promotes mental health.

### **Level 2 — Specific Protection**

In the case of our individual patients in offices or clinics, we expend considerable effort on immunizations against specific diseases. In mental illnesses we have few specifics for prevention at present; possibly the judicious separation of a child from psychotic parents might be considered specific prevention in some cases. Statistics show that a child has only a small chance of *not* becoming psychotic when both parents are schizophrenic. Our knowledge of the few purely hereditary mental illnesses enables us to give some specific preventive advice to patients.

Routine serologic examination of mothers and premarital couples could be considered specific for the prevention of congenital syphilis and its frequent mental symptoms. Prevention of clinical German measles in pregnant women is specific enough to show that we have made progress and are taking the first steps in specific prevention of mental disease.

### **Level 3 — Early Diagnosis and Treatment**

By making ourselves conscious of the early symptoms of developing mental illness and emotional conflict, by becoming aware of the difficulties of the maladjusted child, often resulting from the maladjusted parent and in this manner filling many of the criteria for a "communicable" disease, and by extending efforts to help the troubled child and the parents, we can take steps to early diagnosis and treatment of prepsychotic, emotional problems that so often become the full blown psychotic.

Many of Florida's communities have begun mental hygiene clinics, in an attempt to assist some of these troubled families, sometimes with the help of the practicing physicians, sometimes without. These clinics may or may not be the answer to the maladjusted child, but they represent a community preventive and therapeutic effort based on the best information we have today. They deserve our full interest and support.

### **Level 4 — Limitation of Disability**

In physical illness we believe that the earlier the diagnosis can be made in the course of disease, the more effective the treatment, and usually the better the chance for complete and successful care of the patient. I believe that this same tenet applies to mental disease. The medical profession should more fully support community efforts and need to develop facilities for this function of early diagnosis and prompt treatment. We also have accepted for physical illness the precept that once diagnosis is made, we should undertake full treatment in order to limit any disability that might occur, and we are often irritated by the patient who procrastinates and allows the disease process to progress. Many communities in Florida are allowing mental disease to progress among their citizens through fear, ignorance and misunderstanding of mental illness and antiquated commitment laws. Much of this attitude comes from lack of adequate community leadership in mental health education, much of which should be supplied by the practicing physicians.

### **Level 5 — Rehabilitation**

A fertile area wherein we can attack mental disease is the field of follow-up service. After a person with mental disease is treated, he will need long range careful and sympathetic care and assistance, much the same as the patient who has coronary disease or malignant disease. To enable physicians to perform this task better, a greater portion of our time spent on postgraduate education, short courses, seminars, and journal articles should be aimed to help the practicing physician to assist his patient with mental disease.

### **Research Level**

Research in mental disease needs our wholehearted support and cooperation. It is probably in this endeavor that the eventual solution to the problem lies. Efforts in this field deserve our assistance, cooperation and participation.

Much of this type of research is now in the field of the basic social sciences. This is slow and tedious work, but it is essential. No one thought that the simple mathematical formula derived by Albert Einstein back in the twenties would create the entire new field of artificial radioisotopes and the atom bomb of World War II, nor was the opening wide of the door in virus research anticipated when Dr. John Enders de-



veloped the technic of tissue culture. Similar basic work is needed in the behavioral sciences.

In the meantime we should not wait for the "complete cure" before we fully use what knowledge is available to us. We should stimulate our communities to develop programs that will assist in the promotion of a better mental health atmosphere in which future generations will live. The medical profession should take a position of leadership in this type of community activity, a position that too few of the profession have filled to date.

I hope and believe that more Florida physicians will share some of Benjamin Rush's belief and conclude that his own effort will help the people of his community and that even though many mistakes are made, the sum total will be good and worth the effort. In this way the mental health problems of the State of Florida can be improved, and some of us may even live to see the day when the state mental hospitals have empty beds, as has been accomplished in the state tuberculosis hospitals.

P. O. Box 602.

## Tetanus Neonatorum in Dade County

PAUL W. JAHNIG\*

AND

MICHAEL J. TAKOS, M.D.†

CORAL GABLES

Tetanus neonatorum is the form of tetanus intoxication resulting when infants under 28 days of age are infected by *Clostridium tetani*. This disease carries a high fatality rate. A review of hospital experience in the United States shows an average case fatality ratio of 77 deaths per hundred cases treated.<sup>1</sup> Individual hospitals have reported mortality experiences ranging from 55 to 100 per cent of cases.<sup>2-4</sup> The disease is relatively rare in the United States, but in less fortunate countries the incidence is much higher. Twenty-five cases of tetanus neonatorum were treated in one hospital in Nigeria during the first six months of 1948.<sup>5</sup> This series occurred in an area with an estimated indigenous population of 500,000 persons. It has taken from 10 to 15 years to accumulate series of similar numbers from areas of the United States with nearly double this population.

Infection of the newborn with *Clostridium tetani* is generally considered to take place during delivery or by manipulation of the umbilical cord following birth. The necrotic umbilical stump, tied off from the oxygen supply of the blood, forms an acceptable medium for the growth of the anaerobic saprophytic tetanus bacillus. Furthermore, the growth of *Clostridium* may be enhanced by the presence of areophilic pyogenic bacteria creating localized zones of anaerobiosis.

Tetanus toxin produced during the vegetative growth of the tetanus bacillus diffuses into the systemic circulation of the infant. This powerful organic poison has an affinity for nervous tissue to which it becomes "fixed." After a brief incubation period, the fixed toxin produces the pathognomonic symptoms of the disease. Once fixed in the central nervous system, the toxin cannot be neutralized by any quantity of specific antiserum.<sup>6</sup> Symptoms, however, may be produced when less than a lethal dose of the poison has become fixed. It is believed that the fixed toxin eventually may combine with protein substances and leave the nervous tissues. Some think that this altered form of toxin may have poisonous qualities of its own, but there is no definite evidence for these speculations.

Our present day therapeutic regimens have two basic objectives. First, there is an attempt to neutralize such toxin as may still be circulating in the blood and tissue fluids in an effort to keep a lethal concentration from accumulating in nervous tissues. Secondly, other measures are used to combat the symptoms caused by the poison which is already fixed, so as to prevent death from vascular collapse, convulsions, exhaustion, or acute asphyxia. This regimen has had little effect in reducing the mortality from neonatal tetanus.

This report presents the results of epidemiologic studies of 22 cases of neonatal tetanus reported to the Dade County Health Department during the years 1943-1957. In this 15 year period

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these 22 cases comprised about 13 per cent of the total for all forms of tetanus recorded in Dade County. Eighteen of the infants were born in the county, while four had been brought there for treatment from neighboring areas. Hence, Dade County residents averaged 1.2 cases of neonatal tetanus annually, whereas the over-all incidence of reported cases was 1.5 per year.

### Epidemiologic Studies

In all but one of the cases the patients were treated in local hospitals, and the diagnosis was verified by study of the clinical records. The one patient not hospitalized was seen while in extremis by the physician signing the death certificate, who observed the pathognomonic symptoms of the disease. It is not known exactly how many attempts were made to isolate and identify the causative organism, but in one instance *Clostridium tetani* was recovered by culture from the umbilical stump.

The presenting symptom common to all cases was the inability of the infant to suck. This was associated with difficulty in swallowing whatever food was placed directly in the mouth. Restlessness and fretfulness accompanied the dysphagia. Usually the baby would be unable to open its mouth within 24 hours of the time that difficulty in swallowing was noted. The trismus was accompanied by a generalized hypertonicity of skeletal muscle, rigidity being especially pronounced in the muscles of the abdomen, the jaws, and the extremities. Most of the parents did not seek medical assistance until many hours after pronounced rigidity was present. Risus sardonicus was noted in practically all cases. Many infants showed a tendency to opisthotonos, and in all a series of generalized tetanic convulsive seizures developed.

Each of the babies showed at least some degree of omphalitis when first seen by a physician. In most cases, the desiccating umbilical stump was covered by a grossly purulent exudate; in a few, the infection was less prominent, but still readily detectable. In one case, in which sloughing of the cord had already taken place, it was noted that "the navel was discharging a pink fluid."

The race, sex, and residency status of the patients studied are tabulated in table 1. Negro infants predominated, forming 77.3 per cent of the total cases. During the period of the study, the Negro population of the county averaged about 14 per cent. Thus Negroes and Indians, who

**Table 1. — Race, Sex, and Residence in Neonatal Tetanus Cases, Dade County, 1943-1957**

Race and Sex	Resident	Nonresident	Total
Negro, male	10	1	11
Negro, female	5	1	6
Seminole, male	0	2	2
Seminole, female	1	0	1
White, male	1	0	1
White, female	1	0	1
Total	18	4	22

make up a small proportion of the total population of the area, contributed inordinately to the number of cases of neonatal tetanus. For each white infant with the disease, there were 1.5 Seminoles, and 8.5 Negroes. The ratio of white to Negro cases (1 to 8.5) differs markedly from the 1 to 4 ratio observed at Charity Hospital in New Orleans.<sup>3</sup>

Since neonatal tetanus is an infection acquired shortly after birth, one would reasonably expect that there would be approximately a 1 to 1 ratio of male to female cases, since it is well established that the sex ratio at birth is about 106 male infants to each 100 females. In the cases studied, the ratio of the sexes was 1.75 males for each female. By race, the ratio of the sexes was 1.8 males to each female for Negroes; 2 to 1 for Seminoles; and 1 to 1 for whites. While the figures for Seminoles and whites are derived from too small a series to carry any great significance, the over-all sex distribution in these cases is skewed markedly from the expected. Unfortunately, it has not been possible to learn if this same distribution was noted in previous studies; thus it is not known if the observations relating to a sexual differential in the incidence of tetanus neonatorum in this study represents a real difference or a statistical accident. If the former is true, and a preponderance of males were noted consistently, it would indicate some factor was operating which created favorable circumstances for the establishment of the disease in male infants. One certainly cannot explain this sex differential on the basis of the activity status of newborn male infants as is the case in tetanus in the older age groups.

The length of the incubation period in neonatal tetanus is difficult to judge, since one cannot fix the exact time when infection with *Clostridium tetani* occurred. In all but one of the cases studied the infant was unable to suckle within 14 days of the time that it was born (table 2). The median age at the onset of this symptom was 7.2 days. The only infant surviving the disease did

**Table 2. — Age in Days at Onset of Symptoms (Inability to Suckle) of Neonatal Tetanus**

Age at Onset of Symptoms	Total Cases	Number Surviving	Per Cent Surviving
1 - 3 days	1	0	0
4 - 6 days	9	0	0
7 - 9 days	7	0	0
10 - 12 days	3	0	0
13 - 15 days	1	0	0
16 - 18 days	0	0	0
19 - 21 days	1	1	100
Total	22	1	4.5

not become symptomatic until the nineteenth day following delivery. It is well known that the length of the incubation period in tetanus acquired as a result of trauma has a pronounced effect on the survival rate in this disease. This may be the explanation for survival in this case, although one cannot be sure of just when the infection was acquired.

A study was made of the delivery status of the infants in this series, to learn if there was any common pattern which might account for their becoming infected with tetanus. There was no instance in which the same midwife or physician had attended the birth of more than one infant in which tetanus subsequently developed. The delivery history was known for 18 of the 22 infants studied (table 3.) Of this group, 10, or 55.6 per cent, were delivered at home by midwives; in one case the disease resulted after a home delivery by a physician (5.6 per cent); and in two instances (11.1 per cent) delivery was spontaneous without assistance to the mother. Hence, in 13 cases, or 73.3 per cent, the infant was born at home rather than in the hospital. This proportion was probably higher, since it is suspected that in the four cases without birth records there were also home deliveries. In five babies delivered in approved hospitals tetanus later developed.

It is easy to see how infection may have occurred in the unattended deliveries, since in both instances the infant was expelled directly onto a dirt floor. Likewise, sanitary conditions in

homes where midwife deliveries were made leave much to be desired.<sup>7</sup> In the hospital-delivered cases there is evidence to indicate that infection may have occurred after the baby reached home. In one instance, the mother bathed the umbilical stump of her baby with witch-hazel and alcohol daily after being discharged from the hospital on the third postpartum day. Furthermore, the median age of onset of symptoms in the hospital-delivered cases was eight days, whereas it was five days for infants delivered at home. In this area a three day postpartum stay is the rule in uncomplicated deliveries. Evidently, universal hospital delivery would not eliminate the problem of neonatal tetanus.

There was no particular seasonal distribution of the cases.

### Discussion

Tetanus is of special interest to practitioners in Florida since this state has the highest tetanus morbidity rate in the nation, averaging 1.5 cases per 100,000 population. This morbidity experience is five times greater than the average rate experienced by the entire United States registry area.<sup>1</sup> This state also leads the nation in neonatal tetanus. During 1951-1954, Florida averaged 34.4 deaths from neonatal tetanus per 100,000 nonwhite live births.

In Dade County, neonatal tetanus affects chiefly Negro and Indian infants, and cases occur with greater frequency in these racial groups than their proportionate representation in the population warrants. Some of this difference can be traced directly to the fact that persons in these groups are the ones chiefly serviced by home delivery. It is doubtful, however, that universal hospital delivery would provide a complete answer for the reduction of neonatal tetanus in this area.

The data suggest that unnecessary manipulation of the umbilical stump either through ignorance or superstition may play a large part in the production of the disease. Public health education in better ways of caring for the newborn infant has probably reached the maximum number of persons whom it is now possible to reach through educative methods. Thus the chief hope for prevention of the disease in this area seems to lie in the active immunization of mothers with toxoid during pregnancy, especially in the least literate segment of the population. The resultant titer of transplacentally transmitted passive immunity in the newborn should protect

**Table 3. — Delivery Status in Neonatal Tetanus, Dade County, 1943-1957**

Place of Delivery	By	Number
Home	Midwife	10
Home	Physician	1
Home	Unattended	2
Hospital	Physician	5
Unknown		4
Total		22



the infant during the critical first month of life when the risk is greatest. Furthermore, it would decrease the number of adult women in the population who have not acquired immunity to tetanus. Some have advised against such a procedure because it might complicate the existing programs for immunizing infants. Since, however, injured persons are frequently given both active and passive immunity to tetanus at the same time without interference, it does not seem reasonable to deny the infant a chance to avoid a disease with extremely high mortality rates for this reason.

The interesting sex differential in the incidence of tetanus neonatorum discussed in this report needs confirmation before it can be considered fact. There are two factors operating which might account for this differential. First, mothers may tend to be more protective of female than of male infants. Second, the male infant tends to urinate over the ventral surface of the body, while the female infant's urine tends to soak into the buttock area. Perhaps urine soaking of the umbilical stump helps produce conditions more favorable to the growth of *Clostridium tetani*.

#### Summary

A study of tetanus neonatorum in Dade County showed an average incidence of cases from

this area of 1.5 cases per annum. Negroes and Indians were more frequently involved than their proportionate numbers in the population should allow. The median incubation period from birth to the onset of symptoms was 7.2 days. Over 70 per cent of the cases resulted in infants delivered at home either spontaneously or by midwives. Five of the infants were delivered at hospitals. The median age at onset of symptoms was five days for infants delivered at home and eight days for those delivered in hospitals. It is believed that manipulation of the umbilical stump may play a part in causing infection. It is recommended that pregnant women be immunized with tetanus toxoid as a means of preventing neonatal tetanus in this area.

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# ABSTRACTS

**Preservation of Natural Landmarks in Unilateral Cleft Lip.** By. D. Ralph Millard Jr. J. A. M. A. 169:133-134 (Jan. 10) 1959.

The frequency with which he encountered the harelip deformity in a Korean hospital led the author to realize that all components of a normal lip and nose were more or less present in each person with cleft lip, depending on the severity of the deformity. Concluding that the primary step in construction would be to recognize all existing landmarks and juggle them out of distortion into normal position, he devised an operation which he describes. He also discusses postoperative care and the timing of the operation. In summary, he comments: "It never ceases to be a thrill that two simple incisions can set up a consecutive chain of happy actions: 1. The cupid's bow component, carrying with it one philtrum column and the entire dimple, drops into normal position, leaving a triangular gap above. 2. Advancement of the lateral lip element to fill this gap not only narrows the alar flare and wide nostril floor but unites the cleft along a curving line which simulates the one missing link, the matching philtrum column.

"Several popular methods in use today ignore one or more of nature's landmarks and, what seems even more tragic, by actually destroying them in the primary repair cause them to be lost forever."

**Supportive Adrenocortical Steroid Therapy in Acute and Subacute Cerebrovascular Accidents, With Particular Reference to Brain-Stem Involvement.** By H. J. Roberts, M.D. J. Am. Geriatrics Soc. 6:686-702 (Sept.) 1958.

The author advocates the use of adrenocortical steroids as adjunctive therapy in the management of certain seriously ill patients suffering from acute or subacute cerebrovascular accidents. He reports nine cases in which the use of adrenocortical steroids apparently was life-saving in patients critically ill with cerebral infarction, most of whom were not expected to survive. The beneficial effect was particularly striking in cases of severe involvement of the brain stem. Alleviation of stupor, depression, apathy, paralysis, impaired deglutition, and clouded consciousness was frequently dramatic within 12 to 24 hours. Short term supportive

steroid therapy was of considerable value in the rehabilitation of other patients with persistent hemiplegia or pseudobulbar palsy.

An analysis is presented of the rationale for such therapy, the potential complications, and the relationship to other measures in the treatment of cerebrovascular accidents. It is emphasized that there should be no indiscriminate use of adrenocortical steroids in the treatment of stroke. Pertinent features relating to important but little appreciated aspects of the diagnosis of cerebral vascular accidents are also briefly discussed. It is hoped that others will be encouraged to study this form of therapy and report their experiences. If the beneficial effect is confirmed, adrenocortical steroids may prove to be of great value in improving the plight of certain seriously ill patients suffering from massive strokes.

**Treatment of Chronic Hypoparathyroidism with Probenecid.** By Barkley Beidleman. Metabolism 7:690-698 (Nov.) 1958.

Probenecid (Benemid) inhibits the renal tubular reabsorption of phosphorus from the glomerular filtrate, thereby increasing phosphaturia and decreasing hyperphosphatemia. This action duplicates one effect of the parathyroid gland on calcium-phosphorus balance in the experimental animal and the human. Since 1950, there has been increasing evidence that probenecid may constitute the most satisfactory therapeutic agent available for chronic hypoparathyroidism. Five cases are reported in which this unique drug was used with satisfactory results. In this series, three patients with post-thyroidectomy hypoparathyroidism and two patients with idiopathic hypoparathyroidism received probenecid with satisfactory symptomatic and laboratory response ranging in duration from 10 months to four years and five months.

In one patient, the condition was well controlled on probenecid therapy during pregnancy and she bore a normal infant. In a second patient, a comparison was made of the effectiveness of supplying supplementary calcium entirely by mouth versus administering part of the daily supplement by vein. The effects of AT-10 were also compared with those of probenecid. In this patient, intravenous calcium gluconate was more

effective in increasing phosphaturia and reducing hyperphosphatemia; AT-10 increased calcium excretion, but phosphate excretion dropped to nearly zero; and probenecid definitely increased phosphaturia and reduced serum phosphorus, but was totally ineffective in maintaining normocalcemia.

The mode of action of probenecid in hypoparathyroidism lends strength to the concept of the dual effect of parathormone.

**The Right of a Patient to Die.** By John J. Farrell, M.D. J. South Carolina M. A. 54:231-233 (July) 1958.

Published in full in this issue of The Journal under Others Are Saying.

**Thrombosis of the Terminal Aorta and Horseshoe Kidney.** By David S. Hubbell, M.D. Am. J. Surg. 95:990-993 (June) 1958.

Thrombosis of the distal aorta and iliac arteries, described by Leriche and others, is characterized by symptoms of claudication of hips and lower extremities, impotence, and diminished or absent arterial pulses beyond the aortic bifurcation. Within the last 15 years it has been increasingly recognized as a clinical entity, and recently methods of arteriography and surgery have greatly improved the efficacy of definitive diagnosis and treatment. The most interesting features of the case here reported were the presence of a horseshoe kidney with the Leriche syndrome, the false interpretation gained from the aortogram, and the studies in lipid metabolism. In this case, occurring in a 47 year old man, the upper limit of thrombosis within the aorta lay beneath the renal isthmus of a horseshoe kidney which compressed the aorta. The misleading findings on the aortogram were due to dissection of the dye between the thrombus and the arterial wall. Blood studies showed an abnormal lipid metabolism which indicated the major role in producing the arterial damage to the distal aorta.

**Nasal Injuries in Children.** By C. J. Heinberg, M.D. South. M. J. 51:1548-1555 (Dec.) 1958.

In this age of automobile accidents, athletic injuries, industrial mishaps and many other modes of injury, the nose, because of its prominent position, is often the site of severe trauma. Since nasal deformities may affect an individual's mental well-being and may result in social insecurity

and economic hardship, it is most important to know the proper handling of nasal injury. In presenting the proper method of dealing with such injury in children, the author discusses the general considerations; the types of nasal injuries including those occurring during birth, those occurring prenatally and those of traumatic origin; the management of nasal fractures; the management of septal injuries; and contusions and lacerations of the integument of the nose. The otolaryngologist, he points out, is the logical specialist to diagnose and treat nasal injuries because he is especially trained in the anatomy, physiology and surgery of this structure. Also, it is important to correct septal deformities in childhood because of the development of neuroses which leave a permanent mark on the patient's personality and because the maxillofacial triad is a possible sequela of neglected deformities. Until the recent development of septoplasty, it was not possible to correct septal deformities properly until the child was fully grown because older procedures involved removal of growth centers.

**Aneurysm of Renal Artery: Report of Five Cases.** By Benedict R. Harrow and Jack A. Sloane. Tr. Southeast. Sect. Am. Urol. A. 1958, pp. 1-7, and J. Urol. 81:35-41 (Jan.) 1959.

The object of this paper is to add to the literature five cases of saccular aneurysm of the renal artery, consider the indications for aortography, and discuss the treatment. In this series of five calcified saccular true aneurysms, one developed in a solitary kidney, the third reported in the literature. Noncalcified aneurysms demand operation, the authors state, but, contrary to many previous reports, they believe that operation may be unnecessary with large and small calcified aneurysms in asymptomatic, normotensive elderly persons. Surgery is indicated if pain, hematuria, hypertension or renal impairment occurs and in youthful or pregnant patients. With atypical ring calcifications translumbar aortography should be utilized since this procedure is safe if properly performed. The intelligent use of adequate, closely supervised compression during intravenous urography often eliminates the necessity of retrograde pyelograms in these patients.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.



## Quo Vadis - Medicine

It has been a matter of some concern to me as I have heard many Doctors of Medicine carelessly remark, "I would not allow a son of mine to study Medicine." They attempt to give the impression that we are an underrated, unhonored, underpaid group of social drudges against whom the government, aided by the press, is carrying on a special confiscatory campaign. Medicine is the very last profession they would recommend a young man to take up.

A large proportion of the young men and women of our communities will be returning to the universities and colleges this month, to the centers of education scattered across our nation. Many are going with a definite purpose to study and train for a specific profession or vocation already decided upon. Others have not yet made up their minds as to what field of endeavor they will follow and in the meantime are pursuing study courses of general culture and/or science as a basic background. A younger group of our youth are returning to the secondary schools to prepare themselves for whatever is to come afterward. Many of both of these groups are looking to the generations ahead of them for clues that will influence them as to what occupation they will prepare themselves for. I sincerely hope that none of them listen to the type of unhappy member of our profession to which I have referred.

I pray that the student will in some way know that the "doctor" who describes his profession in such terms has himself either been misplaced or misguided in Medicine and that there are such individuals in every occupational calling.

My advice to the discontented doctor who reasons as stated during this year of 1959 is to read the Introductory Address at the opening of the Forty-Fifth Session of the Medical Faculty of McGill University by Sir William Osler, published in the Canadian Medical and Surgical Journal of 1877: "Some will tell you that the profession is underrated, unhonoured, underpaid, its members social drudges—the very last profession they would recommend a young man to take up. . . . I would rather tell you of a profession honoured above all others; one which, while calling forth the highest powers of the mind, brings you into such warm personal contact with your fellow men that the heart and sympathies of the coldest nature must needs be enlarged thereby."

To the student who is considering the study of Medicine, I have the following to say: Our profession is much older than any philosophy of political government in use today. It has outlived many and I am convinced it will outlive those concepts of government that would seek to destroy it by regimentation or control in one way or another. If you come into Medicine, come ready to work hard, to sacrifice and to fight for the principles for which Medicine stands. Keep in mind the advice of Osler, "Start at once a bedside library and spend the last half hour of the day in communion with the saints of humanity." Remember always that Medicine is an art as well as a science. Learn all you can about both of these component factors from those with experience before you. Apply your knowledge with skill and with dignity and you will never regret your choice of profession.

A handwritten signature in black ink, reading "Ray W. Judd". The signature is written in a cursive, flowing style with a large, prominent 'R' and 'J'.

# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## “For What Is a Man Profited”

The quotation from the Great Physician which begins with this phrase may reverently be paraphrased, “For what is a doctor profited when he devotes unrequired time, talent and money to Organized Medicine?” In recent weeks this question has been in the mind of the recipient of the first “Certificate of Merit” awarded by the Florida Medical Association to one of its members. Experience answers that activity in the scientific and organizational programs of the medical profession does bring the participant many highly prized rewards.

Several years ago the Professor of Surgery in one of our leading medical schools was asked why he attended so many medical meetings and sat through practically every session of the scientific program. His reply ever true: “Ed, this is the way I keep educated in medicine. While I’m in Richmond my time is so crowded and the calls upon my strength are so great that I am too tired to do much reading. I can sit quietly and relaxed in this room and hear another physician present information that not until months later could I obtain only by searching medical literature. Be-

sides, to listen to the author of an idea makes it more impressive.” Obviously, this busy doctor was well profited.

Association of physicians in joint service to their profession promotes friendships of priceless worth. Programs of medical societies afford contacts with members of other organizations in the community whose purpose is to provide service needed for the betterment of our people and country. In fact, these relationships are of such practical profit to the individual that a past president of the Florida Medical Association was heard to say, “Don’t be concerned about paying my expenses. If you made me permanent president, the benefit to my practice from continued contact with the doctors and other leading citizens would generously compensate any cost in time and money such service would entail.” After four decades of observation we have failed to discover one physician who worked for “organized medicine” for the purpose of receiving monetary gain. Likewise, we have not observed one physician whose financial difficulty can be attributed to any kind of contribution he made to the profession of medicine.

Since recorded history, it is known that there has been some organization of doctors. To make this possible, it has been necessary for certain individuals to contribute time, energy, talent and money in order that the organization continue and grow into the influential profession they have left us. They have bequeathed to us the opportunity and responsibility to nourish, provide for, direct and work for this glorious inheritance.

Before Sir Alexander Fleming had gained worldwide recognition for the introduction of penicillin, he said to a group of medical students, "Doctors are, in a sense, a team, and the selfish ones who play only for their own personal ends tend to ruin the team-spirit and lower the standards of their profession." What greater satisfaction can there be to a player than knowing he was a loyal member who unselfishly helped to victory? Organized medicine has won many victories. Through recommendations and cooperation of organizations of doctors with other groups, our medical schools in the United States provide medical education superior to any other in the world. Our hospital facilities and care are the best, and what our people receive professionally when they are sick is not equaled elsewhere. Be-

cause of organized medicine's promotions, there exist a Public Health Service, local and national laws and regulations for the development of the best medical service yet known to man. The preservation of free relationship between the patient and doctor furnishes the strongest bulwark against the devious or direct attacks of socialism. In recent times, the first step toward the socialistic state has been the socialization of medical services.

What any one doctor did or can do or will do in this great moment of organized medicine, though necessarily a small percentage of the total effort, nevertheless is helpful to victory of the team.

Active membership in the Florida Medical Association for more than four decades has brought varied opportunities for participation in the growth of the great body of organized medicine. As one who has been honored by the Association for this service looks back through these years, it is obvious that nothing in his life has brought such rewards as the knowledge that he, too, was accepted to play on the wonderful team of doctors. It has profited him greatly.

EDWARDS JELKS, M.D.

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## The Editorial *We*

*We*, the Journal's newly established Editorial Committee, take this occasion to advise the readers of this page—if, indeed, there be any—of our intentions and proposed policy. Here, then, is what you may expect, editorially, from your Journal—and being thus forewarned may not be imposed upon as "unsuspecting readers."

*We* shall, first of all, attempt to give you two editorials each month: one a therapeutic capsule in the form of a brief, professional medical digest or thought on a timely subject—this to be prepared by an authoritative individual in the field and usually one other than a member of the Editorial Committee; the second, a more conventional type of editorial, dealing with some one of the many controversial, significant and important problems that arise in Medicine today.

*We* hope, by these editorials, which may involve the philosophy—the ethics—the economics and the heritage of Medicine, to stimulate our readers into a more critical evaluation of many

of the older and perhaps outmoded concepts which have become fixed in their minds; and most of all, to stimulate creative, constructive thinking along these lines, which may eventuate in valuable contributions to these pages—to the Florida Medical Association—and to Medicine in general.

*We* shall ask the writers of all guest editorials to sign them and shall append the initials of a member of this Committee to each of his efforts, so that those who would throw stones—or flowers—may have an identified target.

*We* shall continue an argumentative, disturbing, skeptical approach to our editorial tasks until you—our readers and sponsors—direct us, by your comments, to alter it and return to the more conventional broader boulevards of pompous protestations against Sin and Indolence. Until then we invite your arguments, your rebuttals—and even your verbal abuse. We'll even print them.

J. W. A.



**Looking Ahead to 1960  
Annual Meeting  
Jacksonville, April 8-11**

The Committee on Scientific Work of the Florida Medical Association requested the Board of Governors to consider the full use of the week-end days for the 1960 Annual Meeting, and on June 28, 1959, the dates for the 1960 meeting were decided upon by that Board. They are April 8 to 11.

These dates encompass the week end with the meeting starting on Friday noon and continuing through Monday. Within these days there will be allotted equal time as in past years for special interest groups, general interest programs, House of Delegates sessions and other necessary assemblies of a state meeting.

This change in dates has been carried out after careful consideration by many members. It is believed that these dates will allow the physicians of the state to attend the entire meeting with a minimal absence from their patients and a maximal utilization of time usually devoted to extramedical activities.

The special interest groups will continue to have Sunday for their use, and it is hoped that with an attractive program of more general interest on Saturday and Monday many physicians who formerly attended the Association meeting for that one day only will take a more active part in the entire program.

Your Committee on Scientific Work at this time is making an attempt to correlate the programs of the special interest groups and the general assembly meetings in an effort to provide every physician an opportunity to hear each speaker and to give each speaker the largest possible audience.

Make your plans now to attend the 1960 Annual Meeting of your Florida Medical Association at the Robert Meyer and George Washington Hotels, Jacksonville, on April 8-11.

Thad Moseley, M.D.

Chairman, Committee on Scientific Work

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**Florida Academy of General Practice  
Fall Scientific Session  
Miami Beach, Oct. 29-Nov. 1**

The annual Fall Scientific Session of the Florida Academy of General Practice is to be held in Miami Beach on October 29 through November 1, 1959. The sessions and exhibits will be at the Seville Hotel.

The growth of the Florida Academy of General Practice in the past decade has been startling. From a small group of family physicians interested in organizing themselves for the purpose of raising their standards of practice and providing themselves with postgraduate education, the Academy has grown to a body consisting of many hundreds of physicians representative of all communities, both urban and rural, throughout the state. Nationally, the Florida Academy has gained recognition as being an effective force within the confines of the American Academy of General Practice.

Much of the interest of the general practitioners in the state has been sustained by virtue of the annual scientific sessions, held each fall. In previous years medical speakers for these ses-

sions were imported from many other states. Parallel to the growth of the Florida Academy has been the growth in stature of the medical talent within the confines of our own state. The past decade has seen the origin and growth of two fine medical schools. We should all of us be proud of their current status.

With these thoughts in mind, the program committee of the Florida Academy of General Practice decided that the time had arrived when postgraduate study could be made available using the talents for teaching our own state could provide. With the fall sessions being held in Miami Beach, and with the proximity of the University of Miami School of Medicine, it became evident that both these factors could be correlated.

Hence, the meeting in Miami Beach is to be held with the cooperation of the faculty of the School of Medicine of the University of Miami. The program promises to be interesting, stimulating, and absorbing.

The secondary theme for this meeting will be one of relaxation for the participants. In a beautiful setting such as is being provided, much of a social nature is being planned both for the doctors and their wives and the exhibitors and guests.

In addition to the scientific and social plans there will be gifts awaiting all those who pre-register before October 1. Those who wish to preregister should contact Mr. Marshall Brainard, 1453 Louisa Street, Jacksonville.

One of the doctors attending will have the pleasure of taking home with him a fiberglass boat, outboard motor, and trailer. Others will be made happy with dozens of other prizes. In all, the Academy will attempt to make this a gala occasion.

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### **Florida Diabetes Association Meets in Miami Beach October 29-30, 1959**

The Seventh Annual Meeting of the Florida Diabetes Association will be held at the Balmoral Hotel in Miami Beach on Thursday and Friday, October 29 and 30. Cooperating with the Florida Diabetes Association in this annual presentation are the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health, and the Florida Medical Association.

Three distinguished guest speakers will contribute to the program. Dr. Nicholas P. Christy, Associate in Medicine, Columbia University College of Physicians and Surgeons, New York, will speak on "Studies of the Etiology of Cushing's Syndrome" and "Pathophysiology of Hypopituitarism." The subjects to be discussed by Dr. Jerome W. Conn, Professor of Medicine and Director of Metabolism Research Laboratory, University of Michigan Medical School, Ann Arbor, Mich., are "What Constitutes Diabetes and the Prediabetic State in Man" and "Primary Aldosteronism, Clinical Considerations and Results to Date." Dr. Francis D. W. Lukens, Professor of Medicine and Director of George S. Cox Medical Research Institute, University of Pennsylvania School of Medicine, Philadelphia, will lecture on "Insulin and Protein Metabolism," "Assessment of Activity of Sulfonyleureas, Clinical and Experimental" and "A Philosophy of Diabetes."

Member speakers and their topics are: Dr. Andrew E. Lorince, Assistant Professor of Pediatrics, College of Medicine, University of Florida, Gainesville, "Connective Tissue Acid Mucopoly-

saccharides and Their Possible Significance in Endocrine Disorders;" Dr. Bernard H. Marks, Research Instructor, University of Miami School of Medicine, Miami, "Hormonal Control of Fatty Acid Metabolism;" and Dr. George F. Schmitt Jr., Miami, "Kimmelstiel-Wilson Disease."

The registration fee is \$25, and all interested physicians are invited. Additional information may be obtained from Dr. Morris B. Seltzer, Secretary-Treasurer, Florida Diabetes Association, 614 North Peninsula Drive, Daytona Beach.

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### **The American Society of Anesthesiologists, Inc., Annual Meeting, Miami Beach, October 4-9, 1959**

All the physicians in the Dade County area have been invited to attend a panel discussion entitled "The Medical Aspects of Space Travel" which comprises a part of the program for the annual meeting of the American Society of Anesthesiologists, to be held at the Hotel Americana, Bal Harbour, Miami Beach, during the week of October 4 to 9, 1959. The panel will be presented at 9 a.m. on Wednesday, October 7, by a team of United States Air Force specialists, led by Brigadier General D. Flickinger of the Air Research and Development Command. All interested physicians may attend this session. In an effort to assure seating for nonmember Florida doctors, the Florida Medical Association Membership Card will be required for admission. Other sessions are restricted to the society's members and sponsored guests. Attendance at the meeting is expected to exceed 2,300.

The Scientific Exhibit will consist of 19 specially chosen exhibits, including one presented by Drs. Edward A. Talmage and J. Gerard Converse of Miami. Another exhibit will be presented by Dr. Harold Carron of Tampa.

Activities sponsored by the Florida Society of Anesthesiologists will include a luncheon in honor of Dr. Ralph M. Waters, of Orlando, an honorary member of the Florida Society of Anesthesiologists, a past president of the American Society of Anesthesiologists, Inc., and the first university professor of Anesthesiology in the United States, to be given on Wednesday, October 7. The annual dinner dance of the national organization will be held on Thursday, October 8, at 8 p.m.

The Florida Society of Anesthesiology will hold a business meeting on Sunday, October 4, and on that day the first of the refresher courses

of the Tenth Annual Refresher Course Program of the national body will be presented. These courses will continue through October 6 at the Hotel Americana.

Dr. Ralph S. Sappenfield is chairman of the local arrangements committee for the national meeting.

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**American College of Obstetricians and  
Gynecologists  
District IV Meeting  
Miami Beach, October 29-31, 1959**

District IV of The American College of Obstetricians and Gynecologists will hold its annual meeting at the Hotel Americana in Bal Harbour, Miami Beach, on Thursday, Friday and Saturday, October 29, 30 and 31. This district includes the District of Columbia, Florida, Georgia, Maryland, North Carolina, Puerto Rico, South Carolina, Virgin Islands, Virginia, and West Virginia.

Speakers of national renown and district members will present half of the scientific program this year, and the remaining half will consist of papers presented by residents on original investigative or clinical work in the field of obstetrics and/or gynecology. The Miami Obstetrical and Gynecological Society is offering a \$100 Award for the best resident paper given at the meeting. On Friday afternoon there will be an audiovisual program, and at noon on Friday and Saturday panels will be presented by panel members from other areas.

Members of the general arrangements committee include, from Miami, Drs. John D. Milton, Ralph W. Jack, Homer L. Pearson Jr., Richard F. Stover, and James H. Ferguson; from Coral Gables, Drs. Richard F. Forman, Joseph Lomax, Norman W. McLeod Jr., and Edward F. Fox; from Jacksonville, Dr. J. Champneys Taylor; from Orlando, Dr. Chas. J. Collins; from Panama City, Dr. William C. Roberts, and from Tampa, Dr. Harold G. Nix.

Chairmen of the other committees are Dr. Ferguson, scientific program committee; Dr. Stover and Dr. Thomas F. Blake, Coral Gables, panels committee; Dr. Lomax, registration committee; Dr. Forman, entertainment committee; Dr. Reuben B. Chrisman Jr., Coral Gables, women's activities committee, and Dr. Frank W. Hewlett, Coral Gables, finance committee.

The Miami Obstetrical and Gynecological Society is host for the meeting. Dr. Henry H. Caffee of Coral Gables is president of the group.

**Congress of Neurological Surgeons  
Miami Beach, October 28-31, 1959**

The annual meeting of the Congress of Neurological Surgeons, scheduled for Miami Beach on October 28-31, will be held at the Hotel Americana in Bal Harbour. Many outstanding papers will be presented by nationally known physicians in the specialty, and the meeting is expected to attract a large attendance of neurosurgeons from throughout the nation.

The honor guest will be Dr. William J. German, a distinguished member of the faculty of Yale University School of Medicine, New Haven, Conn. As a preconvention activity, a course in neuropathology will be conducted by Dr. Louise Eisenhardt, also of the faculty of the Yale University School of Medicine.

Dr. Irwin Perlmutter of Coral Gables, who is a member of the Executive Committee of the Congress and of the Program Committee for the meeting, is chairman of the committee on local arrangements. Other Florida physicians serving on committees of the organization include Drs. Jack W. Barrett of Miami, J. Cornall Howarth of Orlando, Christian Keedy of Miami, Fariss D. Kimbell Jr. of Pensacola, John M. Thompson of St. Petersburg, and Richard E. Strain of Coral Gables.

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**Annual Meeting of American Society of  
Plastic and Reconstructive Surgery  
Miami Beach, October 18-23, 1959**

The American Society of Plastic and Reconstructive Surgery, largest organized group of plastic surgeons in the country, will hold its twenty-eighth annual meeting at the Hotel Fontainebleau in Miami Beach on October 18-23, 1959. Approximately 500 doctors from the United States, Canada, Mexico, South America and Europe are expected to attend.

Society membership is open in general to doctors who have passed the examinations of the American Board of Plastic Surgery. Board examinations for candidates will be held just prior to the start of the meeting.

Seven Miami surgeons, headed by Dr. Clifford C. Snyder, who is assistant secretary of the society, are in charge of all local arrangements for the meeting. In addition to Dr. Snyder, they include Drs. Thomas J. Baker Jr., George W. Robertson III, James G. Robertson, Leo H. Wil-



son Jr., Thomas J. Zaydon and D. Ralph Millard Jr. Five other Florida plastic surgeons are also society members.

Scientific sessions will be held from October 19 through 23, with the exception of Wednesday, October 21, which will be devoted to a series of study sessions on various phases of plastic surgery. Motion pictures will also be presented.

Among the surgeons delivering papers at the meeting are Drs. George W. Robertson III and Leo. H. Wilson Jr. of Miami. Their topic is "The Difficult Surgery of the Fatty Nasal Tip."

### **Postgraduate Seminar in Neurology Gainesville, September 24-26, 1959**

A program dealing with neurologic disorders commonly encountered in clinical practice has been arranged by the Division of Postgraduate Education of the College of Medicine of the University of Florida and will be presented on September 24, 25 and 26 under the auspices of Dr. Richard P. Schmidt, Division of Neurology, Department of Medicine. Broad topics to be discussed include cerebral vascular disease, convulsive disorders, headache, and back pain. An outstanding faculty will provide authoritative discussion as to the pathogenesis, diagnosis and management of these subjects, each of which is to be presented in a comprehensive manner. Discussion periods and clinical conferences will be utilized to provide understanding of specific problems in the broad categories of disease mentioned.

Speakers will include Dr. Charles A. Kane, Professor of Neurology, Boston University School of Medicine; Dr. Guy L. Odom, Professor of Neurosurgery, Duke University School of Medicine; Dr. Adolph L. Sahs, Professor of Neurology, State University of Iowa College of Medicine; and from the College of Medicine, University of Florida, Dr. Harriet E. Gillette, Assistant Professor of Surgery and Chief of Physical Medicine, Dr. Nicholas A. Greville, Assistant Professor of Surgery, Dr. Lamar Roberts, Associate Professor of Surgery and Chief of Neurosurgery, Dr. Schmidt, Associate Professor of Medicine and Chief of Neurology, and Dr. Robert L. Williams, Associate Professor of Psychiatry and Medicine.

The registration fee for the Seminar is \$25, but interns and residents are exempt from this charge. The course is approved for credit by the American Academy of General Practice. For further information write the Division of Postgraduate Education,

### **IMPORTANT NOTICE TO ALL PUBLIC ASSISTANCE CONTRACT HOLDERS\***

**Effective July 1, 1959, Prescriptions for all Vitamins and Tranquilizers will not be accepted for payment under the Public Assistance Prescription Program.**

Due to the fact that the 1959 session of the Florida Legislature reduced the appropriation for "Prescribed Medicine" and to the fact that the rolls of recipients of "Prescribed Medicine" are increasing, it is necessary that a limit be placed in some manner on the program of furnishing prescriptions to Old Age Assistance, Aid to the Disabled and Aid to the Blind patients.

We have reached a point where we are now processing more than an average of \$260,000 worth of prescriptions per month, and the Department of Public Welfare must hold the figure at not more than \$255,000 per month. We were told that the program would reach three million dollars per year, and it has begun to go above that amount; so a line must be held and the following solution seems to be the most feasible from an administrative standpoint. Rather than place a limit on the amount or number of prescriptions filled or on the price of an individual prescription, it has been thought best to place two categories of drugs on a "NONCOMPENSABLE" basis. Therefore, beginning July 1, 1959 and continuing until further notice, prescriptions calling for VITAMINS and TRANQUILIZERS cannot be accepted for filling and payment under your contract. We realize that it is going to be quite an undertaking to separate these prescriptions from the regular run of prescriptions and it is going to be a task for you to explain to Public Welfare patients that you cannot charge the program with prescriptions for these drugs and that they will have to pay for them out of their own funds.

An amendment to our "Agreement" has been prepared which will become effective on July 1, 1959 and it is binding on all participating pharmacies. The amendment in its entirety is reproduced below and is followed by a list of Tranquilizers which the Department has compiled for your guidance.

### **FLORIDA DEPARTMENT OF PUBLIC WELFARE and FLORIDA STATE PHARMACEUTICAL ASSOCIATION**

#### **Amendment of Agreement for Furnishing Prescribed Medicine**

\*Reprinted from the Florida State Pharmaceutical Association Journal, June 1959, at the request of Dr. Eugene G. Peck Jr., Chairman, Medical Advisory Committee to the State Department of Public Welfare.

Section 2 of the AGREEMENT made the 14th day of August, 1958, by and between FLORIDA STATE DEPARTMENT OF PUBLIC WELFARE and FLORIDA STATE PHARMACEUTICAL ASSOCIATION for FURNISHING PRESCRIBED MEDICINE is amended to read:

2. PRESCRIPTIONS: For the purpose of this contract, an original written prescription on regular printed prescription blank bearing the date written, the name and postal address of the patient and the signature of the prescribing physician, dentist, or osteopath plus a monthly Certification of Eligibility, Form PA-68, will be considered proper payment authorization to a participating pharmacy to fill the prescription within the following definitions:

#### COMPENSABLE ITEMS

- a. In general, drugs prescribed for the care and control of a chronic or an acute illness, disease or injury.
- b. Medical requests of prescribed dressings that are essential to an immediate medical need.
- c. Reserpine (*Rauwolfia Alkaloids*) for treatment of hypertension.

#### NONCOMPENSABLE ITEMS

- a. Treatment and immunization drugs provided by the State Board of Health.
- b. Prostheses and appliances.
- c. Personal care items.
- d. Single or multiple vitamins.
- e. Spiritus Frumenti.
- f. Drugs for hospitalized patients.
- g. Tranquilizers—the derivatives of Phenothiazine, Diphenylmethane, Propanediol and Meproamate.
- h. After appropriate notice, unusually expensive items may be excluded upon medical and fiscal review.

#### REFILLS

Payment will be made for two refills within a 60 day period.

#### QUANTITY

Payment cannot be made for more than a 30 day supply of medicine on an original or refilled prescription.

This amendment to be effective for all prescriptions filled in July, 1959, and subsequent months.

#### FLORIDA STATE DEPARTMENT OF PUBLIC WELFARE

Date: ..... By: .....  
J. Hal Stallings, Chairman,  
State Board

Date: ..... By: .....  
(Mrs.) Charles A. Carroll,  
Secretary, State Board

#### FLORIDA STATE PHARMACEUTICAL ASSOCIATION

Date: ..... By: .....  
R. Q. Richards,  
Secretary-Manager

#### TRANQUILIZERS TO BE CONSIDERED AS NONCOMPENSABLE ITEMS FOR THE PURPOSE OF VENDOR PAYMENTS BY THE STATE DEPARTMENT OF PUBLIC WELFARE.

Compazine Spansules	Deprol	Pacatal
Harmonyl-N Filmtabs	Equanil	Quiactin
Modutrol Tablets	Frenquel	Softan
Sparine HCl Injection,	Halabar	Somatovite
Tablets, Syrup	Harmonyl	Suavitil
Thorazine Spansules	Meprospan	Sycotrol
Atarax	Meprospan	Thorazine
Besertal	Miltown	Trilafon
Compazine	Moderil	Ultran
Dartal	Neo-Slowten	Vesprin
		Vistaril

This list constitutes items which you MAY NOT dispense on P.A. prescriptions; however, combinations of any of them with other drugs of recognized therapeutic activity are permissible and will be paid for under the Program. Such combinations, for example, would include: Dartal with Phenobarbital, Ataraxoid, Equanilate, Equalysin, Milprem, P.M.B. NO VITAMINS means, no single vitamin, no multiple vitamin for either oral or parenteral administration. However, prescriptions for vitamins in combination with other active therapeutic agents wherein the vitamin content is a secondary ingredient may be accepted. Examples: Eldec, Dumogran, Gevrine—containing hormone substances and/or AM-Plus, Amvicel, Vi-dexemin in which the chief ingredient is dextro-amphetamine.

This new regulation does not affect prescriptions you fill prior to July 1, but it does prevent refills of prescriptions calling for medication in either of the categories specified. Be prepared to adhere to this regulation so that you will not have prescriptions returned to you unpaid be-

cause they were for items not allowed, thus resulting in a loss to you.

As much as we dislike this new regulation, it was made necessary because of the reduction in funds allocated by the legislature and by the fact that more patients are being placed on the rolls. It still does not place us in a figure below three million dollars per year that we were told would be expended through the drug stores holding membership in the Florida State Pharmaceutical Association. If it is found that this new regulation makes too deep a cut in the volume, then new directives will be issued.

#### **PLEASE REMEMBER—**

No prescriptions calling for more than a 30 day supply will be accepted for payment.

Not more than two refills in a 60 day period. No prescription may be refilled more than twice.

Do not accept two or more prescriptions in the same month for the same item if each is written for a 30 day supply.

Prescriptions received with the physician's signature in two or more different handwritings will be returned unless same are "Certified as a true copy."

**VETERAN'S PRESCRIPTIONS ARE IN NO WAY AFFECTED BY THIS ORDER; IT APPLIES ONLY TO PUBLIC WELFARE PRESCRIPTIONS.**

### **LETTER TO THE EDITOR**

Dear Shaler:

We are sending this to all County or Component Societies in the State.

As the Chief Medical Consultant for the Department of Public Welfare, I want to bring to your attention some of the salient features of the public assistance vendor payment plan for prescribed medicine. I also want to emphasize several important medical aspects inherent in the program.

As you recall, in September 1958, the Department of Public Welfare established a new plan to pay for prescribed medicine, and this was done on the basis of a statewide need for a better program to provide medicine to State public assistance recipients of Old Age Assistance, Aid to the Disabled and Aid to the Blind. The Aid to Dependent Children program was excluded. This plan has proved to be a means of adequately providing medicine to those who need it and of eliminating situations where the recipient did not purchase medicine with the money provided in the

monthly grant for this purpose. The vendor payment plan is a method of financing the cost of medicine, and in Florida, the plan was designed in such a way that it would not interfere with the doctor-patient relationship. In other words, patients would continue to choose their own physician and the doctor would continue to prescribe for the patient according to the individual's treatment needs. In the majority of the cases, the plan also avoids the use of the cumbersome form PA-56 previously sent to doctors in the adult public assistance categories.

Aspects of the payment plan relating to medical care were determined and approved by a Medical Advisory Committee appointed by the State Board on the recommendation of the Florida Medical Association. The other limitations of the program are the result of planning a program within financial appropriations of the Department.

Thus, the program can be seen in terms of the following criteria:

#### **I. COMPENSABLE ITEMS**

- a. In general, drugs prescribed for the care and control of a chronic or an acute illness, disease or injury.
- b. Medical requests of prescribed dressings that are essential to an immediate medical need.
- c. Reserpine (Rauwolfia Alkaloids) for treatment of hypertension.

#### **II. NONCOMPENSABLE ITEMS**

- a. Treatment and immunization drugs provided by the State Board of Health.
- b. Prostheses and appliances.
- c. Personal care items.
- d. Single or multiple vitamins (effective July 1959).
- e. Spiritus Frumenti.
- f. Drugs for hospitalized patients.
- g. Tranquilizers—the derivatives of Phenothiazine, Diphenylmethane, Propanediol and Meprobamate (effective July 1959).
- h. After appropriate notice, unusually expensive items may be excluded upon medical and fiscal review.

#### **III. REFILLS—Payment will be made for two refills within a 60 day period.**

#### **IV. QUANTITY—Payment cannot be made for more than a 30 day supply of medicine on an original or refilled prescription.**

It should be noted that vitamins and tranquilizers are listed as noncompensable effective



July 1959. The Department will be unable to continue to finance the cost of these items because of the 1959 legislative decrease in appropriations for prescribed medicine.

As an example of the importance and magnitude of the program, our statistical reports show that total payments for the month of April 1959 were \$255,717.87 for 68,542 prescriptions. The average cost of prescriptions was \$3.73, and of the total of 80,260 public assistance cases, 22.88 per cent required prescribed medicine.

Now that the program has been in operation for more than six months, medical and fiscal reviews have begun. We are able to review the number and cost of prescriptions issued to an individual as well as unusually expensive medicines. The vast majority of prescriptions have been in good order and reflect the practice of good medicine. The initial medical review of several thousand prescriptions revealed the following points which are important and should be kept in mind by physicians signing prescriptions:

- I. Quality should not be sacrificed because of expense, but if a cheaper drug fulfills the treatment purpose, it should be used.
- II. Exercise good treatment judgment as to quantity and frequency of medicine prescribed.
- III. Since the program enables complete freedom to physicians in prescribing medicine, the physician carries a great responsibility in preventing abuse of the program. Physicians are, therefore, urged to help the Department continue a program without greater payment limitations and restrictions caused by undue expense, duplication, and frequency of prescribed medicine.
- IV. The best rule for prescribing physicians is to use the same good medical judgment and economic concern in prescribing for public assistance recipients that is used in private practice.

On occasion, I plan to write directly to physicians concerning the drugs prescribed for particular patients. This action will be taken to clarify the treatment circumstances in order to justify program expenditures. Problems relating to the use of narcotics and to medical practice shall be referred to the Narcotics Bureau or to the Department's Medical Advisory Committee.

If there are any individual or additional questions, please write directly to me at the Depart-

ment of Public Welfare, Post Office Box 989, Jacksonville, Florida.

Your interest and concern for the public welfare recipients, as well as for better health in Florida, are appreciated.

Hope soon to discuss this with you.

Sincerely yours,

T. Z. Cason, M.D.,

Chief Medical Consultant

## OTHERS ARE SAYING

### The Right Of A Patient To Die

JOHN J. FARRELL, M.D.

MIAMI, FLORIDA

Recently, during an inspection of our medical school by an accrediting committee, I was asked to delineate my concept of a surgeon and my philosophy of the role of surgery in the educational endeavours of a medical school. Well aware that the committee of five men was composed of three internists, a basic scientist and one surgeon, I was still compelled to give an honest answer and said "First of all, a surgeon is an internist who has had additional training. Secondly, in a medical school, the department of surgery should teach what diseases can and cannot, what diseases should and should not, be treated by surgical philosophical principles and then we should teach the students about all the diseases concerned regardless of whether they are best handled medically or surgically. In other words, we believed in teaching general medicine with the added background of surgical philosophy".

Needless to say, this answer met with considerable comment and the ensuing hour was interesting to say the least. I cite this, not to burden you with the problems of medical education but as a half-hearted apology for the topic I have chosen for this evening. At a gala gathering like this, perhaps one's theme should be light and amusing. But I believe sincerely what I said to that committee. Surgery is not merely a branch of the healing arts; it is philosophy of medicine; if you will, it is a way of life. We cannot be surgeons eight hours a day and something else the remainder of the time. We must eat, live and sleep

A Banquet Address to The South Carolina Chapter, American College of Surgeons—Greenville, S. C., November 22, 1957.

Dr. Farrell is Professor and Chairman, Department of Surgery, University of Miami School of Medicine, Chief of Surgery, Jackson Memorial Hospital.

Reprinted from the July, 1958 Number of The Journal of the South Carolina Medical Association, Vol. LIV, No. 7.

surgical philosophy. As surgeons, in the proper definition of the term, we are concerned not only with life and death but with the myriad facets, liminal and subliminal, surrounding both life and death.

Because of those facts, I would like to take this opportunity to share with you a problem to which there is no ready answer but a problem which all of us face many times, day in and day out. That problem, simply stated is this: "The right of a patient to die". Please do not misunderstand me, I am *not* discussing euthanasia for which I hold no brief; as Hippocrates has said: "I will use that regimen which according to my ability and judgment shall be for the welfare of the sick, and I will refrain from that which shall be baneful and injurious. If any shall ask of me a drug to produce death, I will not give it, nor will I suggest such council".

In our pursuit of the scientific aspects of medicine, the art of medicine has sometimes unwittingly and unjustifiably suffered. We have, on occasion, been so concerned with the "right of all men to live" that we are in danger of forgetting that it is appointed for all men, once to die.

As surgeons we all too often consider death a personal defeat. Like John Donne, an English minister of the 16th Century we feel that: "No man is an island entire of itself, every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is less, as well as if a promontory were, as well as if a man or of thy friends or of thine own were; any man's death diminishes me because I am involved in mankind, and therefore, never send to know for whom the bell tolls, it tolls for thee."

Yet we must acknowledge that death is inevitable. As a child reading biblical stories, I was much impressed with the dignity of death: a patriarch surrounded by his children and his children's children sorrowing but eager to hear the last wise words of counsel dropping from the dying lips. What troubles me is that as a surgeon I have rarely witnessed such a scene. If a patient has a right to die as well as a right to live, he has a right to dignity in either instance. I submit that the death bed scenes I witness are not particularly dignified. The family is shoved out into the corridor by the physical presence of intravenous stands, suction machines, oxygen tanks and tubes emanating from every natural and several surgically induced orifices. The last words, if the patient has not been comatose for the

past forty-eight hours, are lost behind an oxygen mask.

I discuss this, not because I have an answer to the problem but because it is a very real problem which all of us must face. Frequently on the wards of our hospital, my surgical residents come to me actually troubled and concerned. Mr. So and So has widespread metastases and is bleeding, how vigorously should he be treated? What is our proper role as physicians in sustaining life in cases like this? How much or how little therapy is ethically or morally proper? What about his hospital bills? I am inordinately proud of these young men when they raise these questions. At those times I feel confident of the shining future of the surgical profession. If eager young men caught up in the hustle and hurry of a busy surgical service, immersed in the pride and satisfaction of knowledge acquired and techniques perfected pause to consider their role as doctors and humanitarians, then postgraduate surgical residencies are assured of success. Lately I have been struck by the number of times the same discussion and questions arise in informal meetings with other practicing surgeons. There is no doubt that this awareness and concern is pertinent today. Perhaps some of you have read the January 1957 issue of the *Atlantic Monthly*. In that issue a widow wrote an article entitled "A Way of Dying". The opening lines begin "There is a new way of dying today. It is the slow passage via modern medicine . . . . . If you are going to die it can prevent you from so doing for a very long time". The *Atlantic Monthly* commenting on the article said that the large metropolitan hospitals have "made dying . . . an ordeal which has somehow deprived death of its dignity".

*The New England Journal of Medicine* in an editorial comment on the article says "Today's graduate falls heir—and with no extra effort—to the immaculate, modern aseptic skills that can keep a diseased, half-dead, cancerous body alive, by intravenous nourishment and with the magic of penicillin and round-the-clock special nursing, so long that the doctor may emerge in the eyes of the kin with little resemblance to the wise and understanding physician of yesteryear. In that picture known to most physicians the kindly, bearded humanitarian sits quietly by the bedside waiting for his little patient to die or to recover; the decision is not his. There is hidden ignorance and sentimentality in the picture, but there is, paradoxically great strength, beauty and spiritual dignity implicit in the situation portrayed."



The history of medicine is replete with countless examples of the wide swing of the pendulum in medical thought and therapeutic fashions. With the rapid progress of the scientific aspects of medicine, with all the startling new discoveries, ignorance of the latest techniques and practices cannot be tolerated in our enlightened, modern era. The staid old jokes about burying our mistakes no longer elicit a weak smile but merit instead an irritated frown. So the pendulum tends to swing away from the proper balance of the science and art of medicine to a point where all out, heroic measures embodying all the most recent advances and all the ancillary services must be employed in every instance. I might add that this violent swing of the pendulum is not due to the medical profession alone but has received considerable momentum produced by the lay press and the lay public demanding the employment of our "modern miracles".

As I have said, I do not know the answer. I do not believe there is an easy answer to be found in the entire philosophy of surgery. Surgery implies rapid and correct judgments predicated upon intimate knowledge of the sciences of physiology, biochemistry, pharmacology, bacteriology, pathology and anatomy as well as the proper employment of technical skills. However, it also implies meticulous attention to minute detail, intimate knowledge of and an appreciation for the economic, psychosomatic, social and moral as well as the physiologic and pathologic aspects of humanity. Ethical standards are not acquired by the repetition of a pledge nor is a moral sense developed by osmosis alone on the hospital wards. As continuing students of surgery we must also acquaint ourselves with the discussions of sociologists and philosophers. Each one of us must strike a balance between the science and the art of medicine. We must hold to our Hippocratic oath in the light of present day knowledge and our own spiritual values. Each one of us must constantly ask oneself; wherein lies the glory of a technical triumph which precipitates economic, social or spiritual bankruptcy? We cannot allow culpable ignorance to mask itself in the guise of humanitarianism, neither can we allow scientific achievement to preclude the right to live or the right to die with the dignity which is the right of every man. In the last analysis we must seek guidance beyond ourselves and I for one can only repeat that ancient psalm "Out of the depths I cry to thee O Lord, Lord hear my prayer".

BLUE



SHIELD

### If There Were No Blue Shield

Once upon a time, there was a Participating Physician who became so exasperated over differences with his Blue Shield Plan that he called entreatingly upon his favorite pixies, leprechauns and gremlins to arrange for immediate and just disposition. Lo and behold, his plea was heard. Suddenly, there was no more Blue Shield. Strangely, this did not end the trouble. More serious problems arose. As disgruntled patients found themselves more and more pinched to meet the expenses of illness, and less and less inclined to pay doctor bills out of current income, they looked more and more with favor upon the panaceas offered by politicians.

This fairy tale, with its not-so-happy ending, is not beyond the realm of possibility, even probability, unless the Doctors' Plan of voluntary prepayment for medical expenses has the unequivocal support of the medical profession. Much depends upon keeping Blue Shield healthy and growing normally. The very principle of voluntary health insurance hinges upon the continued well-being of Blue Shield. In the opinion of Dr. Donald Stubbs, President of the District of Columbia's Blue Shield Plan and Chairman of the Board of the national association of Blue Shield Medical Care Plans, the whole structure of voluntary health insurance is dependent upon Blue Shield. He believes that Blue Cross would not be able to survive without it, nor would the commercial insurance industry, especially the major medical portion of it. Supporting this contention is the active program of the insurance industry to establish liaison with physicians, hospital management and others in the health care field at local levels. The Florida Medical Association now has a Committee on Commercial Health Insurance. Its counterpart may be found in many other state medical associations. It is reasonable to assume that such activities are not primarily altruistic, for love of physician and fellow man. They are born of necessity.

Which brings to mind the reasons for the birth of Blue Shield. Perhaps Blue Shield today can attribute much of its sturdiness to the nature of its origin, that it was actually an unwanted child, forced to mature and grow strong in the face of opposition from those who should have



been nurturing and protecting it. Dr. Russell B. Carson, President of Blue Shield of Florida, maintains that "Blue Shield was born of two parents—economic necessity and self-preservation," that is, the economic necessity of the patient and self-preservation for the doctor. One fact is certain, the physician had, and still has, no great urge to get into the insurance business. The medical profession did not create Blue Shield as a side line to the practice of medicine. It was a strategic move to forestall political domination. It was fortunate, indeed, that this could be done in a manner which would also perform exemplary public service.

It is this doctrine of service which must be kept alive, which must be extended until it can be made available to all people, everywhere. The fundamental principles of the voluntary, non-profit service plans are service benefits and community service. Depart from—or even compromise—these principles and the uniqueness of service plans, that which makes them attractive and beneficial to the subscribers, will be on its way out. Blue Shield will truly be gone. In its place will be just another insurance company, searching only for the select risks. Since com-

mercial insurance companies must show a profit to remain in business, they are delighted to have the service plans assume the responsibility of providing coverage for those in whom they have little interest. Like some sincere critics from among the medical profession, they advocate service plans providing protection for these only. Service plans cannot survive by covering only the low income group, with its higher than average utilization. If they are to provide community protection, they must have access to every member of the community.

Recently, the force of competition from commercial health insurance organizations, which select their policyholders carefully, has caused the service plans to compromise somewhat by offering supplemental contracts with deductible and co-insurance provisions. These supplemental contracts do not affect the basic service contracts, but provide benefits for services not now covered.

Should Blue Shield and Blue Cross find their days numbered, the ultimate outcome will be government supervision. With them will go the commercial insurance carriers and the freedom of the American physician to practice medicine according to the dictates of his own convictions.

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## The Osteopathic School of Medicine Its Doctors and Its Institutions Today in Florida and the United States

### *The Osteopathic Profession in Florida*

In the State of Florida, 413 doctors of osteopathy practice their profession; this number is approximately 3 per cent of the 13,400 doctors of osteopathy in the United States. The Florida doctors are licensed and regulated under the provisions of the Osteopathic Practice Act and are authorized by statute to have all rights and to be of equal rank and grade with the physicians and surgeons holding the degree of Doctor of Medicine. Applicants for licensure are first required to meet the standards and provisions of the Basic Science Act. Qualified doctors are then licensed to practice osteopathic medicine and surgery by the Board of Osteopathic Medical Examiners under statutory standards of professional education and training similar to those of the Medical Practice Act, including for graduates

*Editor's Note: At a conference in February 1959 between representatives of the Florida Medical Association and the Florida Osteopathic Medical Association, officers of the Florida Medical Association agreed to have published in The Journal of the Florida Medical Association, as a source of information to its members, a factual account of the present status of osteopathy in the state and in the nation, to be prepared by the Florida Osteopathic Medical Association. The informative article here presented was submitted for publication in June 1959. The recent action by the House of Delegates of the American Medical Association, followed by the action of the House of Delegates of the American Osteopathic Association makes this presentation particularly timely.*

since 1948 a required one year hospital internship. Professional regulation and administration under the Osteopathic Practice Act are subject to the same general statutory provisions as are applicable to the Board of Medical Examiners and other professional licensing boards.

These doctors of osteopathy are located in 92 cities and towns of the state. Approximately 146 of the doctors were graduated from osteopathic colleges since 1945. They do not practice in public or private medical hospitals in the state, but confine their hospital care to 18 osteopathic hospitals located in 16 cities in the state furnishing, in all, 425 hospital beds and 88 bassinets. The largest osteopathic hospital has 48 beds and the smallest hospital has 10 beds. These hospitals provide general medical and surgical care. All the osteopathic hospitals are private hospitals, most of them being nonprofit charitable corporations. None of the hospitals are operated by or for the state government. There are, for purposes of comparison, 161 medical hospitals in Florida, and of this number, 65 are of a size of 50 beds or less.<sup>1</sup> Doctors of osteopathy tend largely to be engaged in general practice in the state. Twenty-two are certified in a specialty field of practice by one of the American Osteopathic Specialty Boards. The classifications are in anesthesiology (1), internal medicine (1), pediatrics (3), proctology (5), ophthalmology and otolaryngology (4), roentgenology (2), radiology (1), obstetrics and gynecology (1), and surgery (6). Others are engaged in specialty training programs including residencies and required clinical specialty practice following a residency needed to qualify for certification under one of the American Osteopathic Boards of specialty practice. Two osteopathic hospitals in the state are approved for intern training by the American Osteopathic Association.

Doctors of osteopathy in Florida participate in rendering care under state public health plans, voluntary health insurance, private employer health plans and related health or welfare programs under the same general conditions or requirements applicable to doctors of medicine. Generally speaking, the Florida public health statutes place upon doctors of osteopathy the same responsibilities and duties under such laws as are applicable to doctors of medicine. This situation exists in part because most of such laws place such duties or responsibilities on "licensed physicians" and that term legally has been con-

strued to include doctors of osteopathy and doctors of medicine.<sup>2</sup>

### **The Six Osteopathic Colleges**

There are only six colleges of osteopathic medicine in the United States. They are:

1. Chicago College of Osteopathy, Chicago, Ill.
2. College of Osteopathic Physicians and Surgeons, Los Angeles, Calif.
3. College of Osteopathic Medicine and Surgery, Des Moines, Iowa.
4. Kansas City College of Osteopathy and Surgery, Kansas City, Mo.
5. Philadelphia College of Osteopathy, Philadelphia, Pa.
6. Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

These colleges are the only colleges in the United States or elsewhere granting the degree of Doctor of Osteopathy. They are approved by the Bureau of Professional Education and Colleges of the American Osteopathic Association, and otherwise as described in a later paragraph. The osteopathic profession has no foreign medical school problem, and only 192 doctors of osteopathy practice outside of the United States or its territories.

The Educational Standards established by the Bureau of Professional Education and Colleges of the American Osteopathic Association are published annually in the January Educational Supplement to the Journal of the American Osteopathic Association.<sup>3</sup> This Educational Supplement contains detailed information and statistics concerning all phases of preprofessional and professional education. In addition, Medical School Inquiry—Staff Report to the Committee on Interstate and Foreign Commerce, House of Representatives, Eighty-Fifth Congress, First Session, a study recognized as one of the most comprehensive ones made concerning medical education, on pages 115 to 145 contains further detailed information concerning osteopathic professional education, as well as on the educational programs of United States medical schools, foreign medical schools, and schools of dentistry and public health. The study is basic to efforts of the federal government to provide financial aid to the primary medical training resources of this country.

### **The Matriculation of Students**

Applicants to osteopathic colleges today number approximately two applicants for each ad-



mission. The colleges conduct inquiries into the moral, personal, and social characteristics of the applicants. Osteopathic colleges utilize special tests to determine the qualifications of applicants, the best known of these tests being the Medical College Admissions Test administered by the Educational Testing Service of Princeton University, which approximately 85 per cent of those admitted to osteopathic colleges take. Three osteopathic colleges use the University of Minnesota Multiphasic Personality Index as a part of their admissions test. Four osteopathic colleges have a psychiatrist on their admissions committee. The osteopathic colleges rely heavily upon the recommendations of the premedical committees of the preprofessional colleges, and upon interviews conducted by members of the osteopathic profession in the locality where the applicant resides.

#### **Required Preprofessional College Education**

At the present time all six osteopathic colleges, and all but one medical school approved by the American Medical Association in the United States require of all applicants a minimum of three years preprofessional college education prior to matriculation. Harvard Medical School requires only two years of preprofessional college training, and the Johns Hopkins University School of Medicine will require only two years of preprofessional college study after Sept. 1, 1959. Contrary to preconceived notions, both medical and osteopathic colleges, while requiring a fairly large list of required subjects, accept students with averages as low as C or C plus for admission.

The policies of over 50 percent of medical schools call for no more than C or C+ averages, and 30 percent of schools indicate minimal grade-average policy.<sup>4</sup>

Thirteen per cent of the matriculants in osteopathic colleges drop out because of academic failure, financial difficulties, or other reasons, and about 5 per cent in medical schools for the same reasons. In March 1959, 1,942 students were in training in the six schools of osteopathy. Approximately 467 students graduated in June 1959. In the fall of 1958, 66 per cent of the entering students in osteopathic colleges had received a bachelor's degree from their preprofessional college. Both medical and osteopathic colleges in the United States, while meeting the minimum standards of preprofessional education established by their national professional associations, retain

considerable local authority in accepting students. Both professions require the same basic preprofessional subjects, such as chemistry, English, mathematics, zoology and related subjects.

#### **Professional Osteopathic Education**

The osteopathic colleges include in their curriculums the same basic science subjects in the freshman and sophomore years and clinical subjects in the third and fourth years as presented in approved medical colleges. The Committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association in 1955 made the following conclusions concerning osteopathic education as a part of its lengthy study report:

Current curriculums in colleges of osteopathy include all subjects taught in present-day schools of medicine. In addition, there are courses dealing with the musculoskeletal system and manipulative therapy. The degree of emphasis upon these courses is variable and is diminishing. At none of the colleges was there evidence that these courses interfered with the achievement of sound medical education.<sup>5</sup>

The colleges utilize hospital outpatient and clinic instruction for students in their junior and senior years. The six usual basic science departments of anatomy, pathology, bacteriology, physiologic chemistry or biochemistry, physiology, and pharmacology are found in the osteopathic colleges. The clinical instruction in the junior and senior years in osteopathic colleges falls into similar compartments, such as the Departments of Medicine or Osteopathic Medicine, Surgery, Obstetrics, Pediatrics, Neurology, Psychiatry, and other clinical areas. The instructors and professors in the basic science subjects are generally full time men on the faculties, while in the clinical years the faculty members are doctors of osteopathy, who may or may not be full time men, and if not, the instruction will be partially given by part time doctors engaged in private practice in the localities of the schools. Some clinical departments may have a fairly large percentage of full time men and others few, relying more on part time men. The objective of osteopathic colleges is to train a well rounded general practitioner, capable of advancing into specialized practice upon the completion of further postgraduate training. All of the osteopathic colleges have some postgraduate teaching responsibilities, but they are limited largely to interns and residents, and some United States Public Health Service fellowships in both undergraduate and graduate medicine. Regular short postgraduate courses for



practicing physicians are also conducted by the colleges. Some doctors of medicine teach in osteopathic colleges, but no doctors of osteopathy teach in medical schools. Four doctors of medicine, for example, are on the faculty of the Chicago College of Osteopathy.

All of the osteopathic colleges are located in states where all of the doctors of osteopathy may qualify for an unlimited license to use drugs and perform operative surgery. All osteopathic schools have a Department of Pharmacology similar to that in medical schools, and it is this department which is responsible for instruction in the area most closely related to instruction in the use of drugs. The subject of materia medica is now an obsolete course in both medical and osteopathic colleges. The clinical use of drugs and surgery are taught during the third and fourth year externships which the students serve in the teaching hospitals and outpatient clinics. During this period, students prescribe and administer drugs and assist in surgery under the direction and supervision of the clinical instructors. Development of the teaching in surgery follows the usual pattern commencing with anatomy in the basic sciences and being followed up in the clinical years with observation and assisting in surgical operations. The case records of osteopathic hospitals are maintained in accordance with standard medical procedure and cover the usual hospital entries or records maintained in medical hospitals. With the exception of the Detroit Osteopathic Hospital, Detroit, Mich., a 425 bed teaching hospital of the Chicago College of Osteopathy, and the Osteopathic Unit of the Los Angeles County General Hospital, the 500 bed teaching unit of the College of Osteopathic Physicians and Surgeons, the teaching hospitals of the osteopathic colleges do not run as large in size as those affiliated with medical schools. Most of the osteopathic teaching hospitals fall into the 100 bed to 225 bed capacity as compared with medical teaching hospitals, which are usually in the 300 bed to 500 bed category or larger.

#### College Approval and Accreditation

The American Osteopathic Association (A.O.A.), through its Bureau of Professional Education and Colleges, is a constituent member of the American Council on Education. The American Association of Osteopathic Colleges (A.A.O.C.) also is a constituent, or voting, member of the American Council on Education. It is represented on the Bureau of Professional

Education and Colleges of the American Osteopathic Association.

Every four years the American Council on Education publishes "American Universities and Colleges," which includes all undergraduate institutions and all approved professional colleges in the United States. The last edition of "American Universities and Colleges" was published in 1956. Part II of this book is entitled "Professional Education in the United States." Pages 162 and 163 include a section on osteopathy dealing with the history of osteopathic education, furnishing educational statistics about osteopathic education and listing the approved colleges of osteopathy. This section specifically states that the American Osteopathic Association, through its Bureau of Professional Education and Colleges, is recognized "by the various state licensing authorities and departments of the Federal Government as the accrediting agency of osteopathic colleges." Approval of the osteopathic colleges includes their general hospitals, which are a part of all osteopathic colleges.

Apparently, there still exist some misunderstandings in various areas over the official accrediting procedures for undergraduate education in the United States. There are six accrediting associations responsible for the accreditation of institutions with liberal arts and general programs, and, in some cases, those with special programs in undergraduate education, such as engineering. These associations are as follows:

The New England Association of Colleges and Secondary Schools

The Middle States Association of Colleges and Secondary Schools

The North Central Association of Colleges and Secondary Schools

The Northwest Association of Secondary and Higher Schools

The Southern Association of Colleges and Secondary Schools

The Western College Association

Undergraduate institutions in a state come under the jurisdiction of the appropriate regional accrediting agency. The University of Miami, for example, is approved by the Southern Association of Colleges and Secondary Schools. The University of Miami School of Medicine, on the other hand, or any other United States medical college, is approved only by the Council on Medical Education and Hospitals of the American Medical Association. In other states the same can be

said, namely, that nonprofessional education comes under the regional accrediting agency, and the professional education under the appropriate professional accrediting agency, which for the medical educational institutions is the American Medical Association and for osteopathic colleges is the American Osteopathic Association.<sup>6</sup>

Osteopathic college education credits are accepted by leading universities including Michigan State University, Syracuse University, University of Omaha, and others under a combined degree program permitting osteopathic students to receive their bachelor's degree while in their first or second year in osteopathic colleges. This combined degree program is fully explained in the Educational Supplement to the Journal of the American Osteopathic Association.

### Hospital Internships

A hospital internship is a condition for licensure of osteopathic doctors graduating since 1948 under the present Osteopathic Practice Act, but not under the Medical Practice Act of Florida. Twenty-nine states, including Hawaii, and the District of Columbia today require, by law or regulation, an internship as a condition for the unlimited licensure of doctors of medicine and 24 states, including Hawaii, and the District of Columbia require a hospital internship for doctors of osteopathy. Hospitals providing intern training must, in the states having such a requirement, be approved by the professional licensing boards. In the medical profession such hospitals are voluntarily approved by the Council on Education and Hospitals of the American Medical Association and for the osteopathic profession by the Bureau of Hospitals of the American Osteopathic Association. No medical or osteopathic college requires an internship as a prerequisite to the Doctor of Medicine or Doctor of Osteopathy degree. An internship in the osteopathic profession is a 12 month hospital training program covering the fields of medicine, surgery, obstetrics, and related fields such as pediatrics, radiology and anesthesiology, and meeting the standards for intern training established and administered by the Bureau of Hospitals of the American Osteopathic Association. All but seven of the 439 graduates of osteopathic colleges in 1958 are now engaged in completing their one year hospital internship.

### Specialty Boards and Residencies

Boards or colleges of specialty practice or certification are maintained under the direction of the American Osteopathic Association. The standards of the specialty boards are published in the March issue of the Journal of the American Osteopathic Association.<sup>7</sup> A recent study<sup>8</sup> indicated that 845 doctors of osteopathy in the United States limit their practice to one of the recognized specialty fields such as surgery, obstetrics, psychiatry, or pediatrics, there being 12 American Osteopathic Boards of specialty certification in all. The same study indicated that 1,333 of the 13,400 doctors of osteopathy in the United States limit their practice to manipulative practice. The great percentage are in general practice.

The licensing of doctors of osteopathy itself does not involve residency training; other than that in some states, doctors serving hospital residencies in such specialties as surgery, obstetrics, pediatrics, psychiatry and related fields may be exempt from licensure during the hospital residency period, which is generally three years in length. No state requires a residency as a condition to licensure. Residencies are a condition to certification by the 12 voluntary specialties boards of the American Osteopathic Association. In surgery, for example, the American Osteopathic Board of Surgery requires a person seeking certification in surgery to have assisted during his formal training in not less than 400 major surgical operations and to have performed a minimum of 200 major surgical operations on his own responsibility upon completion of his three years of formal training.

### Research

Research is recognized as a desirable part of the functions of an osteopathic college and the education of an osteopathic physician and surgeon. The osteopathic colleges do not have, however, the finances or personnel to provide training in research to anywhere near the extent available in medical schools. The United States Public Health Service provides some research grants, fellowships, and also postdoctoral fellowships to the osteopathic colleges and osteopathic graduates. Research in the osteopathic colleges is directed at basic studies of fundamental phenomena of the musculoskeletal system, and not at areas relating to current therapy. Reports on the

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1. Hodges, F. T.:  
GP 14:86, Nov., 1956.

research programs of the osteopathic profession are periodically reported in the Journal of the American Osteopathic Association and in other scientific journals.

## Licensing of Doctors of Osteopathy in Other States

The doctors of osteopathy are licensed fully to practice medicine and surgery, or under a license including the use of drugs and surgery, in 37 states, including Hawaii, and in the District of Columbia. The licensing boards in these unlimited license states are in 16 states composed of doctors of osteopathy only; in 17 states of both doctors of medicine and doctors of osteopathy; in three states of doctors of medicine only; and in two states there are two boards, one composed of doctors of osteopathy only and the other composed solely of doctors of medicine, but only the medical board may issue an unlimited license. The legal standards of the medical and osteopathic boards are comparable; 25 of the boards in all, as noted, require an internship as a condition to licensure. All require that the doctor of osteopathy be a graduate of one of the six osteopathic colleges approved by the American Osteopathic Association. Ninety-two per cent of the doctors of osteopathy practice in the unlimited states, and a large percentage of the other doctors of osteopathy hold unlimited licenses in states other than the states in which they are located. In the years between 1952 and 1956 alone, Boards of Medical Examiners issued 1,296 licenses to practice medicine and surgery to doctors of osteopathy.

The medical examining boards which license doctors of osteopathy to practice medicine and surgery in all instances have a majority of their members with the Doctor of Medicine degree. In a state like Texas, for example, three doctors of osteopathy are members of the Texas Board of Medical Examiners, and doctors of osteopathy have been licensed to practice medicine and surgery since 1907. In Colorado, they have been licensed to practice medicine and surgery since 1917, and in other states for similar long periods of time. In another state, Kansas, a new Kansas Healing Arts Board with five doctors of medicine and three doctors of osteopathy was established in 1957, and a doctor of osteopathy is, this year, serving as the President of the Board. One or more doctors of osteopathy serve, in addition, on the Boards of Medical Examiners in the states of Colorado, Delaware, Indiana, Kentucky, Massa-

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chusetts, New Jersey, New York, Ohio, Oregon, South Dakota, Virginia, Wisconsin, and Wyoming, and in the District of Columbia.

The unlimited licenses issued to the doctors of osteopathy vary in name and may be called a physician's and surgeon's certificate, or a license to practice medicine and surgery, medicine, osteopathic medicine and surgery, or osteopathy, or a similar name.

#### **Status of Doctors of Osteopathy Under Federal Laws**

Doctors of osteopathy and doctors of medicine have almost an identical status under federal laws. The most important exception is that while doctors of osteopathy are eligible to be appointed to the Medical Corps of the Army, Navy, and Air Force as Commissioned Medical Officers, no such appointments have yet been made. Doctors of osteopathy are now serving as Medical Officers of the United States Public Health Service and Veterans Administration. A fairly large number are Reserve Medical Officers of the United States Public Health Service and serve on active duty for two weeks of each year. Osteopathic doctors provide medical services or prepare medical certificates under all of the various federal laws requiring such services or certificates.<sup>9</sup>

Osteopathic colleges receive educational grants from the United States Public Health Service to assist the training of student doctors in mental health, cancer, and cardiovascular diseases. Numerous osteopathic hospitals have received large federal grants-in-aid to assist in their construction under the Hill-Burton Act. A United States Public Health Service report recently published compared the knowledge of students in osteopathic and medical colleges receiving cancer

teaching grants.<sup>10</sup> The results showed the osteopathic students had a slightly greater cancer treatment knowledge in the freshman and sophomore years and the medical students in the junior and senior years. The differences, however, were not great in any one year. A federal bill supported by the United States Department of Health, Education, and Welfare and by President Eisenhower favors financial grants for the expansion of medical and osteopathic schools. Federal regulations in some of the health plans require that a participating doctor possess an unlimited license, as for example the Medicare Program for dependents of Armed Forces personnel. In such instances, the few doctors of osteopathy in the limited states may not participate because of limited licensure. The basic law enacted by the United States Congress in 1929 regulating the practice of medicine and osteopathy in the District of Columbia provides:

The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations.

#### **Accreditation of Hospitals**

There are approximately 400 osteopathic hospitals in the United States providing general hospital care, including those earlier referred to located in Florida. These hospitals are located in 22 states. They provide an estimated 12,000 hospital beds. In some areas, particularly in the less heavily populated urban areas, they may furnish the only available hospital facilities or an important part of such facilities. The American Osteopathic Hospital Association is the official national membership organization of the hospitals.



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but the registration or approval program for such hospitals is maintained by the American Osteopathic Association.

There are categories of accreditation of hospitals in both the medical and osteopathic professions. The various states license medical and osteopathic hospitals under state hospital licensing laws, and in addition, the professional licensing boards approve hospitals for intern training. The American Osteopathic Association conducts a voluntary hospital accreditation program through its Bureau of Hospitals and "registers" hospitals for general medical and surgical care; it also "approves" hospitals for intern and residency training in accordance with prescribed standards. The American Medical Association "approves" medical hospitals for intern training. The American Hospital Association "lists" medical hospitals for general medical and surgical care, and the Joint Commission on Accreditation "accredits" medical hospitals with 25 or more beds. The medical and hospital organizations do not permit doctors of osteopathy on the staffs of hospitals which they approve, list, or accredit. The American Osteopathic Association, on the other hand, does not prohibit doctors of medicine from serving on the staffs of osteopathic hospitals, or public hospitals jointly staffed by doctors of osteopathy and doctors of medicine, which are approved or registered by it.

### The Approach of the Osteopathic School of Medicine

The approach of the osteopathic school of medicine has been greatly influenced by advances in scientific medicine. The colleges from the earliest days included instruction in drugs and surgery, although this fact was for a long period of time questioned. In a Missouri decision<sup>11</sup> in 1952, the St. Louis Court of Appeals set forth the corporate charter of the original school established in 1892, the Kirksville College of Osteopathy and Surgery:

The object of this Corporation is to establish a College of Osteopathy, the design of which is to improve our present system of Surgery, Obstetrics and treatment of diseases generally and place the same on a more rational and scientific basis to impart information to the medical profession and to grant and confer such honors and degrees as are usually granted and conferred by reputable Medical Colleges, to issue diplomas in testimony of the same to all students graduating from said School under the seal of the Corporation with the signature of each member of the faculty and of the President of the College.

(Continued on page 340)

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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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1. Innerfield, L.: Clinical report cited with permission
2. Clinical report cited with permission



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(Continued from page 336)

Trial court Findings of Fact and Conclusions of Law in this case held that the College had, from its beginning, included all areas of diagnosis and therapy, including drugs and surgery, as a part of its curriculum and course of training.<sup>12</sup>

The intervening years until the present day were ones which saw differences of opinion between the medical and osteopathic professions. The Journal of the American Osteopathic Association, in particular, in recent issues has sought to reconcile these differences and places much of the burden for the differences on semantics. In simplest language, the approach of the osteopathic profession has been that it recognizes the importance of the musculoskeletal system, along with the other body systems, in the diagnosis and treatment of human ailments and diseases. It is not contended that all disease is caused by derangements of the musculoskeletal system, but that evaluations of such factors should be considered in treating the patient as a whole person. Manipulation, along with other therapies of physical medicine, is adaptable to the treatment of derangements of the musculoskeletal system. The osteopathic doctor utilizes manipulative procedures where needed in practice. As noted earlier, the number of doctors of osteopathy restricting their practice to a manipulative practice approximates 10 per cent.

It is well to remember that manipulation itself is an old therapy, going back for its origin to the days of Hippocrates. Osteopathy as a school of medicine helped to bring new attention to this therapy. Current medical publications discuss its use frequently. James B. Mennell, M.D., author of "The Science and Art of Joint Manipulation," in his text states:

An enormous amount of human disability and suffering is amenable to treatment by manipulation, even to the extent of cure. There are other conditions in which manipulative treatment can be of service in reducing disability to the minimum, when without it the patient would suffer unnecessary disability or discomforts. There is no doubt that the final downward fall into complete incapacity can often be postponed in cases of incurable disease by manipulation. I can, however, only say that my experience so far has failed to convince me that any ordinary pathological process within the body is altered materially for the better or the worse with three exceptions: First, there are many complaints which owe their origin entirely to disturbance of joint function and recovery is impossible unless the joint function is restored to normal by manipulation; second, that the symptoms which can arise as a result of a joint derangement will often simulate organic disease and that these cases remain incurable unless the joints are examined and the necessary adjustment made; third, that if pathological changes within the body are pres-





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ent, a great deal may be done for the benefit of the patient by joint manipulation, even though it has no direct effect upon the main pathological condition present.

The osteopathic position is that osteopathy's training and education fall within the scope and character of modern scientific medicine. The 1955 American Medical Association report itself stated that the courses in the colleges dealing with the musculoskeletal system and manipulative therapy did not interfere with "the achievement of sound medical education." The unlimited practice of medicine and surgery in some states for as long as 60 years, and in Florida for over 30 years, in the care and treatment of disease supports this position. There does not appear to be any greater problem involved in the integration of manipulation with drugs and surgery in the osteopathic profession than there is in the use of physical medicine by the medical profession.

**The American Medical Association, the American Osteopathic Association, and the Relationships of Doctors of Medicine and Doctors of Osteopathy**

For a long period of time, the American Medical Association, under its Code of Ethics, has declared that the practice of osteopathy consti-

tutes "cultist" healing and that, therefore, voluntary associations between doctors of medicine and doctors of osteopathy are unethical. This ruling does not prohibit "involuntary associations" between them.<sup>13</sup> Where by public law, regulation, or health needs of patients doctors of osteopathy and doctors of medicine are required to or must associate together, the American Medical Association does not in any way prohibit such joint activity because it is involuntary. Thus, doctors of osteopathy attend postgraduate education at such medical schools as the University of Colorado School of Medicine, University of California School of Medicine and University of Washington School of Medicine, and staff jointly a minimum of some 75 public hospitals operated by counties or cities throughout the country. In addition, certain private hospitals are jointly staffed by doctors of medicine and doctors of osteopathy; for example, Rio Hondo Hospital in Downey, Calif., is approved for the training of interns by the American Osteopathic Association.

The Code of Ethics of the American Medical Association is construed differently throughout the country by the various state medical societies and medical organizations. The Kansas Medical Society, for example, holds that voluntary relation-



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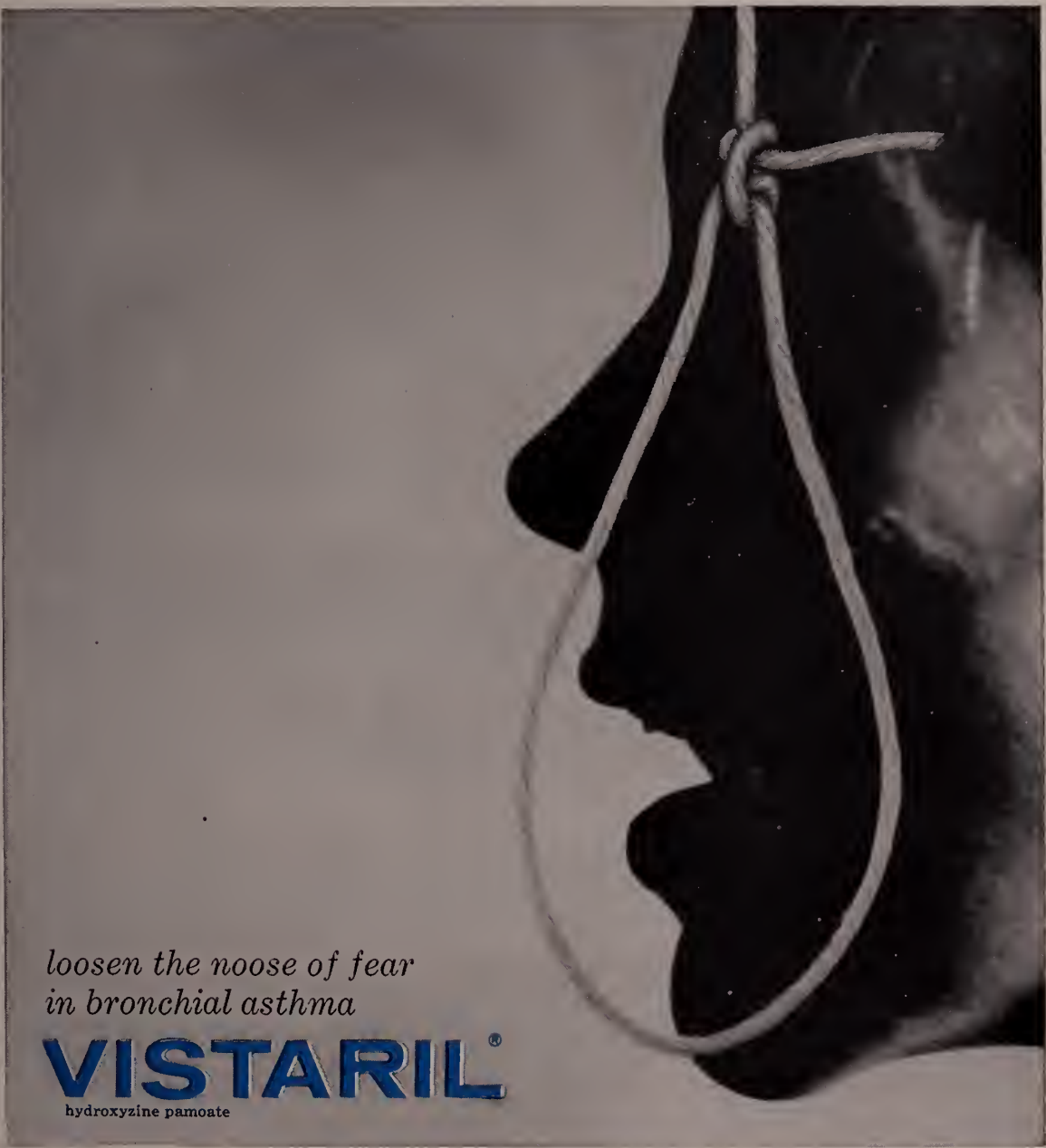
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ships between doctors of medicine and doctors of osteopathy are ethical and that there is no ethical prohibition preventing joint activities of doctors of medicine and doctors of osteopathy based apparently upon the health needs of the people. The Mayo Clinic of Rochester, Minn., will accept referrals of patients and send reports back to doctors of osteopathy, but some other medical institutions will not. Doctors of osteopathy in New England and interns at the Massachusetts Osteopathic Hospital attend postgraduate courses given by the Post-Graduate Medical Institute, Boston, Mass., a school carried on by leading medical organizations and schools in Massachusetts. Doctors Hospital, an osteopathic hospital in Columbus, Ohio, has a part of its basic science instruction in its residency programs presented by instructors of the Ohio State University College of Medicine, a medical school approved by the American Medical Association.

In the years between 1952 and 1955, the Committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association and the Conference Committee of the American Osteopathic Association met and

discussed the matter of the relationships between the professions. The first report of these conferences was published in the June 20, 1953, issue of the Journal of the American Medical Association and the second report in the July 2, 1955 issue of that Journal.

The position of the American Medical Association itself was stated to be:

The American Medical Association is dedicated to the purpose of improving the health and medical welfare of the American people. The osteopathic profession supplies medical care to millions of Americans. In many areas, the only immediately available medical care is by osteopaths. . . . The past of Osteopathy is unimportant. Its present, and particularly its future, are important to the medical care of the American people.

The American Medical Association reports previously referred to were prepared by a committee which included in its membership, at one time or another, members of the Board of Trustees of the American Medical Association, the present Executive Vice President of the American Medical Association, the immediate past chairman of the Board of Trustees of the American Medical Association, the present chairman of the

*(Continued on page 350)*

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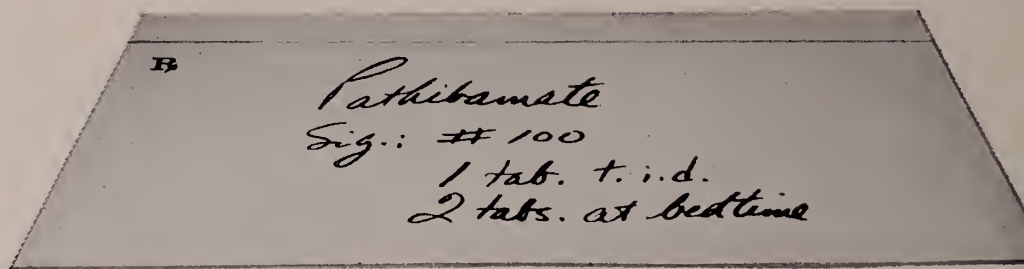
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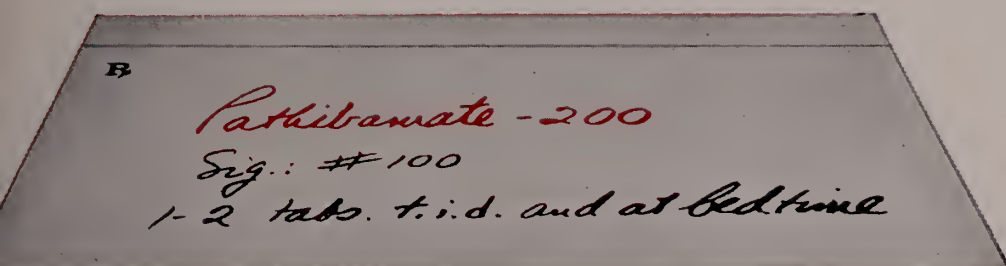
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(Continued from page 344)

Board of Trustees of the American Medical Association, a past president of the American Medical Association, and other medical educators and leaders of the profession.

At the June 1955 meeting of the House of Delegates of the American Medical Association, the recommendations of its Committee for the Study of Relations Between Osteopathy and Medicine failed to receive the approval of the House of Delegates by a vote of 101 to 80. At the June 1958 meeting of the House of Delegates, a resolution requesting that the matter of the relationship between doctors of medicine and doctors of osteopathy be further studied by the House of Delegates was introduced by a delegate representing the Missouri State Medical Association. This resolution made reference to the previous study of the Committee for the Study of Relations Between Osteopathy and Medicine and requested that the matter of relationships between doctors of medicine and doctors of osteopathy be given further consideration. The resolution was not acted upon by the House of Dele-

gates. In Minneapolis in December 1958 at the Clinical Meeting of the American Medical Association, the following action was taken:

Osteopathy: No. 10.—Dr. Wendell C. Stover, Indiana, introduced a resolution which requested the House of Delegates of the American Medical Association to recognize that the constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states.

The Reference Committee on Medical Education and Hospitals discussed the resolution at great length; it noted with favor that the American Osteopathic Association has amended its objectives as stated in its Constitution by deleting reference to the cultism of Andrew J. Still. However, the committee did not believe the resolution offered the appropriate solution to this problem and therefore recommended that (1) the resolution not be approved, (2) that the Judicial Council be requested to review the past pronouncements of the House of Delegates with respect to osteopathy and the status of the laws of the various states in this regard, and (3) that the Judicial Council, if possible, present its report and recommendations at the next meeting of the House.<sup>14</sup>

The special report on the subject of osteopathy, made by the Judicial Council to the House

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of Delegates at the 108th Annual Meeting of the American Medical Association in June 1959, led to the adoption by the House of the following policy statement regarding interprofessional relations:

(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

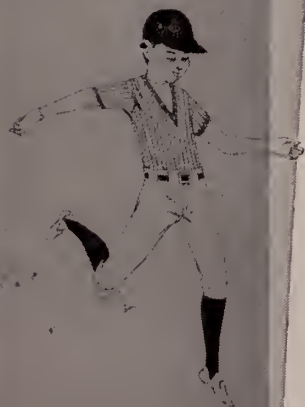
(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals.

(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including interprofessional relationships on a national level.

In another action relating to osteopathy at that meeting, the House of Delegates of the American Medical Association recommended that

its representatives on the Joint Commission on Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

The matter rests here at the present time. There is little doubt that the American Medical Association's study reports of 1952 and 1955 have resulted in better relationships between doctors of medicine and doctors of osteopathy throughout the country. The two reports have received wide attention and discussion, not only in medical and osteopathic circles, but also in governmental circles. Most of the present problems involving doctors of medicine and doctors of osteopathy would be eliminated by the dropping of the "cultist" designation by the American Medical Association in its application to doctors of osteopathy. The June 1959 policy statement of the American Medical Association regarding interprofessional relations marks another forward step in improving the relationship between the two professions, but the policy statement as it now stands "is too high a price to pay," so stated the President of the American Osteopathic Association at the July



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meeting of the House of Delegates. The following resolution adopted by the House at the same meeting represents the official position relative to the present policy of the American Medical Association.

That the osteopathic school of medicine in the interest of providing the best possible health care to the public shall maintain its status as a separate and a complete school of medicine, co-operating with all other agencies and groups that sincerely promote the same objective, when that cooperation is on an equal basis granting full recognition to the autonomy and contribution of the osteopathic school of medicine.

### Conclusion

The osteopathic profession in Florida is a part of a national profession of doctors who, by law, and by training and education, are physicians and surgeons. It is a highly organized profession and has the same pride and confidence in its national, state and affiliated educational and professional organizations as the medical profession has in its organizations. The Florida Osteopathic Medical Association stresses the importance of both professions helping their members to develop objective views toward the other profession, and of making of primary importance the

welfare of the patients. It was estimated in 1952 that doctors of osteopathy were providing complete health care to some 9,000,000 Americans, and the number has undoubtedly increased since that time. It is this group of Americans who are affected by unsatisfactory relationships between the medical and osteopathic professions.

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**W**HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

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## STATE NEWS ITEMS

Dr. Reuben B. Chrisman Jr. of Coral Gables and Dr. Homer L. Pearson Jr. of Miami have been appointed general chairmen for the annual meeting of the American Medical Association scheduled June 13-17, 1960 at Miami Beach. Drs. Franklin J. Evans and Robert P. Keiser of Coral Gables will serve as associate chairmen.

Dr. Louis M. Orr of Orlando, President of the American Medical Association, will be one of the principal speakers at the Tennessee Valley Medical Assembly being held September 28-29 at the Read House in Chattanooga. The title of Dr. Orr's address will be "The Decisive Edge."

Dr. Richard C. Cumming of Ocala was principal speaker at the recent dedication of the new George E. Weems Memorial Hospital at Apalachicola. Dr. Cumming appeared as a member of the advisory committee on hospitals of the State Development Commission.

Dr. Theodore W. Hahn of Deerfield Beach has been engaged in postgraduate work at Jackson Memorial Hospital in Miami.

Dr. Richard T. Farrior of Tampa has returned from New Orleans where he presented a paper at a meeting held in the New Orleans Plastic Surgery Hospital.

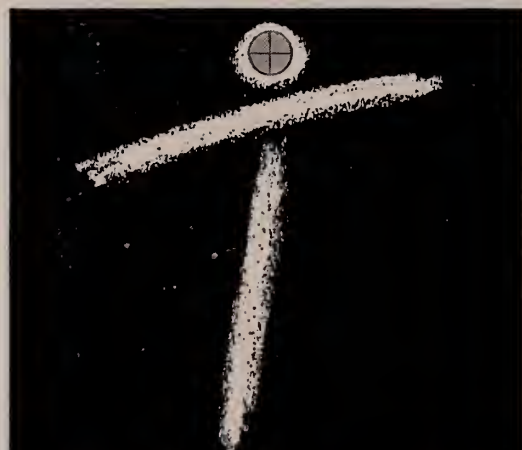
Dr. Reuben Zucker of Orlando has been presented a bronze medallion by the Waterbury Heart Association "in appreciation of distinguished service and leadership in advancing the heart program" in the Connecticut city.

Dr. Oren A. Ellingson of Tampa has returned from an extensive trip to South America where he visited various clinics and hospitals.

Dr. Ray C. Wunderlich of St. Petersburg has been awarded a Wyeth Laboratories pediatric residency fellowship. Dr. Hugh A. Carithers of Jacksonville is a member of the committee which selects recipients of the fellowships.

The Mid-Atlantic Meeting of the International College of Surgeons has been scheduled for November 16-18 at the Homestead Hotel, Hot Springs, Va.

(Continued on page 370)



**JUST ONE TABLET DAILY**

provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .  
**WHENEVER SULFAS ARE INDICATED**

**KYNEX**

Sulfamethoxypyridazine Lederle

**0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION**

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York

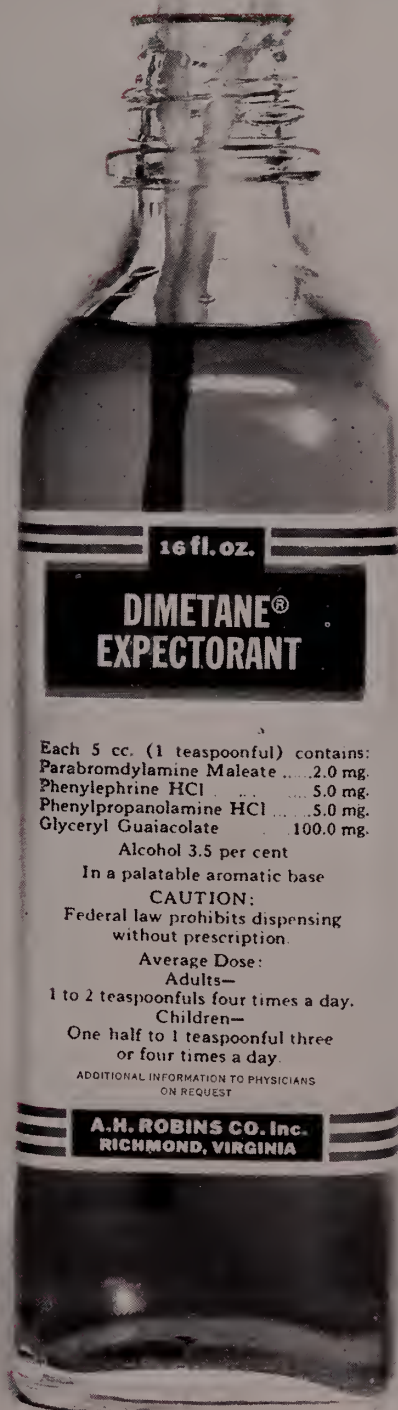




new  
for  
cough

tastes  
good

works  
better



the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceryl Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.

combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

Dimetane® Expectorant  
Dimetane® Expectorant-DC





# **NIAMID\***

**the mood brightener**

**Lifts the  
burden of  
depression...  
opens the way  
for a sunnier  
outlook**

## **New areas of therapy**

NIAMID is clinically effective in a broad range of depressive states, including: involuntal melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic-depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, whether due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

## **New safety**

NIAMID, in extensive clinical trials, has not been associated with the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

## **Background of NIAMID**

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these mood depressions is seen with a rise in the levels of serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine level proportionately.

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**PFIZER LABORATORIES**

Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.





Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of both serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

## Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

## Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

## Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

## References

Complete bibliography and Professional Information Booklet are available on request.

\*TRADEMARK FOR BRAND OF NIALANIDE



**NIAMID**  
*the mood brightener*





helping the hypertensive to help himself...

# THEOMINAL<sup>®</sup> R.S.

(Theominal with Rauwolfia serpentina)

- Gradual but sustained reduction of blood pressure
- Mild bradycardic action
- Alleviation of congestive headache, vertigo, dyspnea
- Relief from anxiety, excitability, insomnia
- Sense of well-being

Theobromine ..... 320 mg.  
Luminal<sup>®</sup> ..... 10 mg.  
Rauwolfia serpentina  
alkaloids (alseroxylon) ..... 1.5 mg.\*

**DOSAGE:** The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until resumption is indicated.

**SUPPLIED:** Bottles of 100 and 500 tablets.

\* = 0.3 mg. reserpine in activity

Winthrop LABORATORIES • NEW YORK 18, N. Y.



# Now — All cold symptoms can be controlled



## Tussagesic

timed-release tablets

### *Controls congestion*

with Triaminic,<sup>1,2,3</sup> the leading oral nasal decongestant.

### *Controls aches and fever*

with well-tolerated APAP, non-addictive analgetic<sup>4</sup> and excellent antipyretic.<sup>5</sup>

#### *Each TUSSAGESIC Tablet provides:*

TRIAMINIC® ..... 50 mg.  
(phenylpropanolamine HCl ..... 25 mg.  
pheniramine maleate ..... 12.5 mg.  
pyrilamine maleate ..... 12.5 mg.)

#### *Dormethan*

(brand of dextromethorphan HBr) ..... 30 mg.  
Terpin hydrate ..... 180 mg.  
APAP (N-acetyl-p-aminophenol) ..... 325 mg.

*References:* 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in *Drugs of Choice*, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in *Current Therapy*, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in *Drugs of Choice*, Mosby, St. Louis, 1958, p.547.

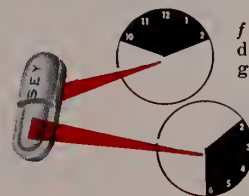
### *Controls cough centrally*

with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,<sup>6</sup> as effective as codeine.

### *Liquefies tenacious mucus*

with terpin hydrate, classic expectorant.

#### *Prompt and prolonged relief because of this special "timed release" design:*



*first* — the outer layer dissolves within minutes to give 3 to 4 hours of relief

*then* — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

*Dosage:* One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

**TUSSAGESIC SUSPENSION** provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



1 1/4 Grs. Ea.

## Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the efficacy, potency and purity of Bayer Aspirin, the world's first aspirin.

And the same manufacturing skill, the same 106 ingredient and product tests, the same exclusive processes which contribute to the superiority of Bayer Aspirin set the standards of excellence for Bayer Aspirin for Children.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1 1/4 grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New  
Tamper-Proof  
Cap







Bed of *Digitalis purpurea*  
with *Campanula* (Canterbury Bells) in foreground

Not far from here are manufactured  
from the powdered leaf  
Pil. *Digitalis* (Davies, Rose)  
0.1 Gram ( $1\frac{1}{2}$  grains) or 1 U.S.P. *Digitalis* Unit.  
They are physiologically standardized,  
with an expiration date on each package.  
Being *Digitalis* in its completeness,  
this preparation comprises the  
entire therapeutic value of the drug.  
It provides the physician with a safe and effective  
means of digitalizing the cardiac patient  
and of maintaining the necessary saturation.  
Security lies in prescribing the  
"original bottle of 35 pills, Davies, Rose."

*Clinical samples and literature sent to physicians on request*

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UNIQUE  
ANTIARTHRITIC.  
ACTIVITY

CLINICALLY  
PROVEN...  
POTENT...SAFE...



# ARTHROPAN<sup>T.M.</sup> LIQUID

BRAND OF CHOLINE SALICYLATE, PATENT PENDING

"Our most striking case was that of a 55 year old white male with rheumatoid arthritis, steroid intoxication, duodenal ulcer, taking 40 mg. triamcinalone/day. He is now on Choline Salicylate [Arthropan] alone and has returned to work."<sup>1</sup>

"In a group of patients who habitually develop gastric distress to moderate dosages of aspirin...all tolerated the new preparation [Arthropan] exceedingly well..."<sup>2</sup>

"Patients who had been taking steroid preparations before using Choline Salicylate [Arthropan] were able to reduce the doses (of steroid) and in some instances to discontinue it entirely."<sup>3</sup>

"In no instances did gastrointestinal symptoms preclude administration of Choline Salicylate [Arthropan]."<sup>4</sup>

These reports have emanated from extensive clinical trials<sup>5</sup> in thousands of patients by more than 180 physicians.

**RECOMMENDED DOSAGE:** (Adults and children over 12 years) *As an anti-inflammatory agent in rheumatoid arthritis and rheumatic fever:* 1-2 teaspoonfuls, 4 times daily at onset of therapy. *As an analgesic or antipyretic:* 1 to 2 teaspoonfuls, 3 to 4 times daily.

**NOTE:** Unless satisfactory relief is obtained, it is advisable gradually to increase dosage by increments of 1 teaspoonful per day until maximum benefit, without side effects, is attained. *In every case the dosage should be adjusted upwards or downwards to assure full therapeutic activity up to the limit of the patient's tolerance (in the absence of gastrointestinal distress or early salicylism).*


Because of the special chemical structure of 'Arthropan', alkalis or other buffering substances are not required to protect the stomach wall and should not be administered with 'Arthropan'.

**SUPPLIED:** 16 and 8 oz. bottles. Each ml. of 'Arthropan' contains 174 mg. of Choline Salicylate. Each teaspoonful (5 ml.) contains 870 mg.

**CITED REFERENCES:** 1. Clark, G. M.: Personal Communication, 1958. 2. Feldman, H. A.: Personal Communication, 1958. 3. Scully, F. J.: Treatment of Rheumatic Disorders with Choline Salicylate (to be submitted for publication). 4. Friedland, C. K.: Personal Communication, 1958. 5. Complete data available on request to the Medical Director.

 *The Purdue Frederick Company*

DEDICATED TO PHYSICIAN AND PATIENT SINCE 1892  
NEW YORK 14, N. Y. | TORONTO 1, ONTARIO



to prevent the  
sequelae of u.r.i.  
...and relieve the  
symptom complex

# ACHROCIDIN<sup>®</sup>

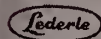
Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.<sup>1</sup> To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN<sup>®</sup> Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H. Am. J. Hygiene 71:122 (Jan.) 1933.

it  
started  
as a  
"cold"...



LEDERLE LABORATORIES,  
a Division of  
AMERICAN CYANAMID COMPANY,  
Pearl River, New York



## new hope for fetal salvage

## DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein<sup>1</sup> in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that in Delalutin-treated women, fetal salvage of infants below term

weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long acting.

According to Tyler and Olson,<sup>5</sup> "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . ."

## DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTERS



Mary Ann Cribben  
Garden City, N. Y.



Amy Sue Greenman  
Lincolnwood, Ill.



William Peller  
Skokie, Ill.



Randy Sinis  
Denver, Colo.



Richard Miller  
Denver, Colo.



Scott Knudsen  
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H.-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J. A.M.A.* 169:1843, 1959.

# DELALUTIN<sup>®</sup>

*improved  
progestational  
therapy*

SQUIBB HYDROPROGESTERONE CAPROATE

DELALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-  
pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated  
with genital malignancy; infertility with inadequate corpus luteum function; production of  
secretory endometrium and desquamation during estrogen therapy; premenstrual tension;  
ysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

## Administration and dosage:

Because of its low viscosity, Delalutin may be admin-  
istered with a small gauge needle (deep intragluteal  
injection). Complete information on administration  
and dosage is supplied in the package insert.

## Supply:

Delalutin is available in vials of 2 and 10 cc.,  
each containing 125 mg. of hydroxyproges-  
terone caproate in sesame oil, and benzyl  
benzoate.

Of these healthy, normal babies was born by a mother with a documented previous history  
of habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



Anna Rutkowski  
Roselle, Ill.



Rosanne Guberman  
Elmont, L.I., N. Y.



Kenneth Michael Simonson  
Denver, Colo.



Karen Mary Nederman  
East Williston, N. Y.



Daniel A. Fabrizio, Jr.  
No. Massapequa, L.I., N. Y.



Elaine Verderosa  
Hartford, N. Y.



J. Gettemy  
Hartford, Conn.

SQUIBB



Squibb Quality—the Priceless Ingredient

<sup>®</sup>DELALUTIN<sup>®</sup> IS A SQUIBB TRADEMARK.



Whenever  
the diet is faulty,  
the appetite poor,  
or the loss of food  
is excessive

*through vomiting  
or diarrhea—*

## Valentine's MEAT EXTRACT

stimulates the appetite,  
increases the flow of  
digestive juices,  
provides: supplementary  
amounts of vitamins, minerals  
and soluble proteins,  
extra-dietary vitamin B<sub>12</sub>,  
protective quantities of  
potassium, in a palatable and  
readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE is 1 teaspoonful two or three times  
daily; two or three times this amount for  
potassium therapy.

**VALENTINE Company, Inc.**  
RICHMOND 21, VIRGINIA

(Continued from page 358)

The 45th annual clinical congress of the American College of Surgeons will be held in Atlantic City, September 28-October 2 with headquarters in Convention Hall. More than 10,000 Fellows of the College and guests from all over the world are expected to attend.

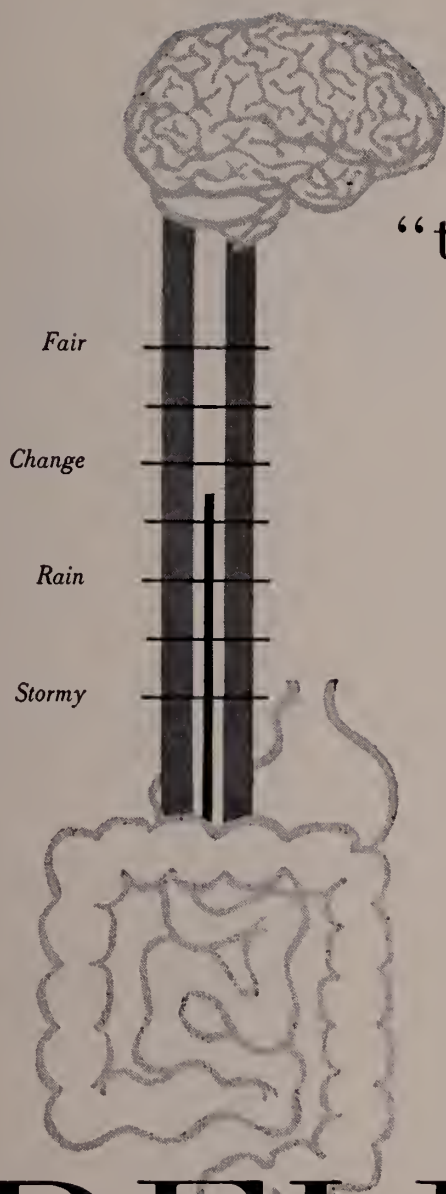
Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, will be in Oklahoma City, October 2 where he will present an address entitled "People Who Live in Glass Houses Shouldn't" as a part of the Symposium on the Senior Citizen sponsored by the Department of Postgraduate Education of the University of Oklahoma Medical Center. On October 11, Dr. Wachtel is scheduled to address a meeting of the Alabama Academy of General Practice in Birmingham and on October 22 he will be in Miami Beach for the annual meeting of the Medical-Dental-Hospital Bureaus of America where he is to present an address on "The Four Freedoms in Medical Practice."

An International Symposium on Griseofulvin and Dermatomycoses will be held at the University of Miami School of Medicine, October 26-27. Under the sponsorship of the Department of Medicine, 50 American and foreign authorities will discuss the mechanism of action of griseofulvin, its experimental toxicology, and its use in fungus diseases of the hair, skin and nails. Information may be obtained from Dr. Harvey Blank, Professor of Dermatology, University of Miami School of Medicine, Miami.

Dr. William C. Thomas Jr. of Gainesville, Assistant Professor of Medicine and Director of Postgraduate Education of the College of Medicine, University of Florida, will be one of the principal speakers at the Twenty-Fourth Piedmont Post Graduate Clinical Assembly scheduled for September 16-17 at the Clemson House in Clemson, S. C.

The postgraduate course "Introduction to Clinical Electrocardiography" will be offered by Mount Sinai Hospital, Miami Beach, October 5 to December 28. The faculty is composed of Drs. Victor H. Kugel, Director; William H. Bernstein; Milton E. Lesser; David A. Nathan; Philip Samet, and Paul N. Unger. Since enrollment is limited, it is important that registration be made promptly with Mount Sinai Hospital, 4300 Alton Road, Miami Beach. The tuition fee is \$25.





“the G-I tract  
is the  
barometer  
of the mind...”

*Belbarb*

*soothes the agitated mind  
and calms the G-I spasm  
through the central effect  
of phenobarbital and the  
synergistic action of  
fixed proportions  
of natural belladonna  
alkaloids on the  
gastrointestinal tract.*

# BELBARB

SEDATIVE ANTISPASMODIC

*20 years of clinical satisfaction*

**Belbarb No. 1; Belbarb No. 2; Belbarb Elixir; Belbarb-B; Belbarb Trisules**

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provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .

WHENEVER SULFAS ARE INDICATED

# KYNEX

Sulfamethoxypyridazine Lederle

0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York



## COMPONENT SOCIETY NOTES

### Broward

The Broward County Medical Association's second annual dinner for retired physicians living within the community has created much enthusiasm in this group. In fact, steps toward the organization of these members of the medical profession in this area are now under consideration as a result of these meetings.

The dinner this year was held at the Beach Club Hotel in Fort Lauderdale late in May with 27 guests from 17 states honored; one 97 and one 94 years of age. Others were in the 80's and late 70's. A warm welcome was extended by Dr. Miles J. Bielek, president of the Association.

Past presidents also were honored at the dinner. Each was presented a certificate of appreciation for his services to organized medicine and to his community.

### Lake

The June meeting of the Lake County Medical Society was held at the Elks Club in Lees-

(Continued on page 378)

## The distinctive PREMIERE suite

By *Hamilton*



Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere—and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort

and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basin and pull-out step are included.

# SURGICAL SUPPLY COMPANY

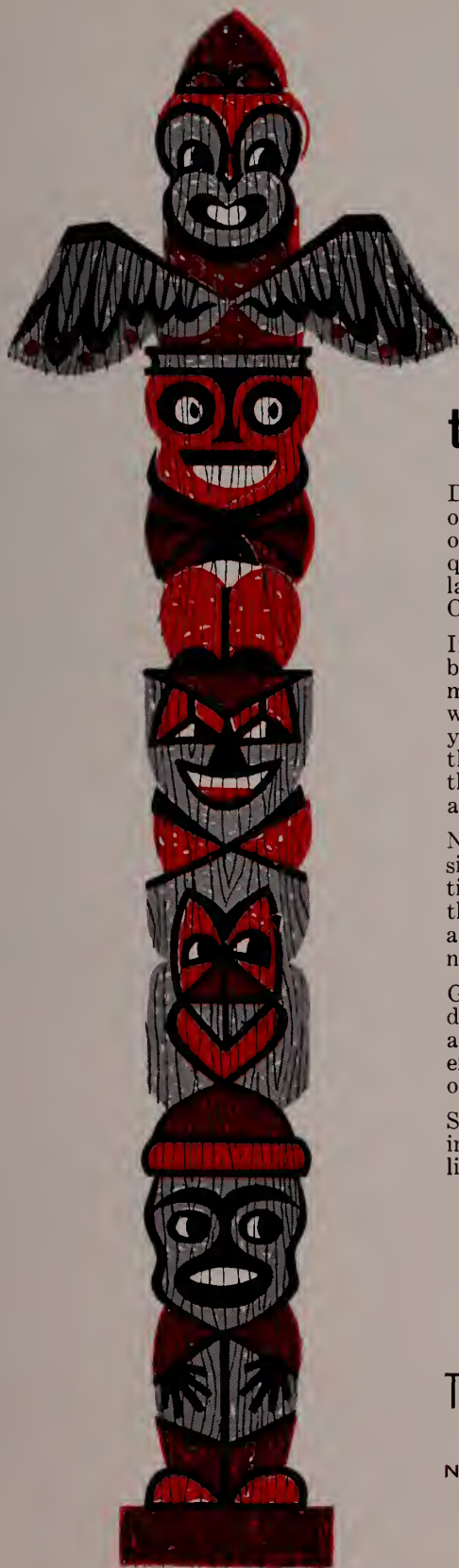
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P. O. Box 2580

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J. BEATTY WILLIAMS



## the **disease** of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is “one of the most widespread and serious protozoan diseases of man,” yet “there is no parasite more often misdiagnosed than is *E. histolytica*.” Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

## new **Glarubin**

TABLETS

*specific for intestinal amebiasis*

### THE S. E. **MASSENGILL** COMPANY

BRISTOL, TENNESSEE

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Today all around us cut-rate and discount houses flourish. You can buy glasses from \$7.98 up. GOOD VISION comes a shade higher. In fact you can't put a price on vision. Your GUILD OPTICIAN endeavors to place the finest in eye wear before the public at the lowest possible prices.

Guild of Prescription Opticians of Florida



Remarkable  
relief from  
low back pain and  
dysmenorrhea

*Trancopal*

THE FIRST TRUE TRANQUILAXANT



# Here is can expect prescribe

## case profile no. 2758\*

A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

*\*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

for low back pain





# what you when you

THE FIRST TRUE TRANQUILAXANT  
**Trancopal<sup>®</sup>**

for dysmenorrhea  
*and premenstrual tension*



## case profile no. 3347\*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

# *THE FIRST TRUE TRANQUILAXANT* **Trancopal**

## potent muscle relaxant effective tranquilizer

- In musculoskeletal disorders, effective in 91% of patients.<sup>1</sup>
- In anxiety and tension states, effective in 88% of patients.<sup>1</sup>
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

### Indications:

#### Musculoskeletal:

Low back pain (lumbago, etc.)  
Neck pain (torticollis, etc.)  
Bursitis  
Rheumatoid arthritis  
Osteoarthritis  
Disc syndrome  
Fibrositis  
Ankle sprain, tennis elbow, etc.  
Myositis  
Postoperative muscle spasm

#### Psychogenic:

Anxiety and tension states  
Dysmenorrhea  
Premenstrual tension  
Asthma  
Angina pectoris  
Alcoholism

### Now available in two strengths:



Trancopal Caplets®:

**100 mg.** (peach colored, scored), bottles of 100.



Trancopal Caplets:

**200 mg.** (green colored, scored), bottles of 100.

**Dosage:** Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

1 Collective Study, Department of Medical Research, Winthrop Laboratories.

*Winthrop* **LABORATORIES**  
New York 18, New York



# Aluscop

CAPSULES

ANTICHOLINERGIC • ANTISECRETORY • ANTI-ENZYME • ANTACID

*with a medical splint*

Aluscop capsules, a unique preparation equally as effective as the liquid form, provide rapid and prolonged relief of pain, discomfort and dysfunction in the management of peptic ulcer, hyperacidity, gastro-intestinal spasm or hyperirritability.

## **Aluscop** TREATS THE ENTIRE DYSPEPTIC SYNDROME

- **Methscopolamine nitrate**—the most potent antisecretory agent—35 times that of atropine sulfate, inhibits gastric acid secretion and acts as a "medical splint" through its visceral antispasmodic action.
- **Dihydroxy aluminum aminoacetate and magnesium hydroxide**—two of the most effective antacids—exert dual action without constipating effect.
- **Sodium lauryl sulfate**—a pepsin inactivator—minimizes pepsin erosion and further destruction of tissue to hasten healing of lesions.

**Composition:** 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

**Dosage:** 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

**Supplied:** Bottles of 100 capsules and 12 oz. of suspension.



Lloyd, Dabney & Westerfield, Inc.

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*Fine Pharmaceuticals Since 1894*



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# KENT'S SUPER-POROUS MICROPORE PAPER

With the intensive publicity being given to porous cigarette paper in recent weeks, Kent believes that doctors would be interested in knowing the scientific facts about the paper used in today's Kent cigarettes.

Kent's exclusive super-porous Micropore paper lets cool air in, lets heat escape through microscopic pores in the paper. The increased oxygen in the tobacco cylinder brings about more complete combustion of the tobaccos. As a result, Kent smokers have been getting a cooler, cleaner, fresher taste in smoking.

When the advantages of Kent's Micropore paper are coupled to Kent's other superiorities, it is easy to understand why more people, during the past year, changed to Kent

than to any other cigarette in America.

Kent smokers also enjoy a free and easy draw, which brings through the rich taste of Kent's costly blend of 100% natural tobaccos. In addition, Kent's exclusive Micronite Filter has made a significant contribution in the area of filtration: Kent has reduced tars and nicotine to the lowest level among all leading brands.

The American smoking public was quick to respond to Kent. They discovered—it makes good sense to smoke Kent, and good smoking, too.



If you would like for your own use the booklet, "The Story of Kent," write to:  
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Research Department  
200 East 42nd Street  
New York 17, N. Y.

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day and night—ulcer control with **B.I.D.** dosage



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Daricon is a remarkably potent and well tolerated antisecretory/antimotility agent. Its *naturally* prolonged action provides day and night relief of pain and symptoms associated with peptic ulcer, functional bowel syndrome, biliary tract dysfunctions, and other gastrointestinal disorders characterized by spasm, hypermotility, and hypersecretion.

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CASES RESPOND**

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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

<sup>\*</sup>Trademark

*(Continued from page 372)*

burg. There was no scheduled speaker; a social hour, dinner and business session made up the program. The next meeting of the Society was announced for the first of September.

### NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baumann, David P., Tampa  
Denton, Peyton S., Palm Beach  
Gillette, Harriet E., Gainesville  
Harrison, William H. Jr., Daytona Beach  
Hendrickson, Floyd C., Key West  
Johannsen, Max W., Palm Beach  
Lipinski, Stanley W., Lakeland  
Lipton, Alan A., Miami  
Mahrer, Martin P., Miami  
Neill, John S., Tampa  
Nikolaus, Donald G., Dunedin  
Peck, Leatrice K., Hollywood  
Scott, Walter P., Jacksonville  
Winslow, Kenneth L., Fort Lauderdale

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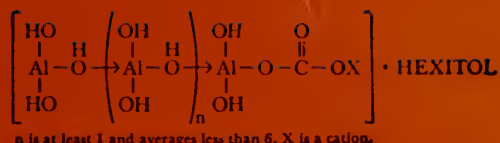
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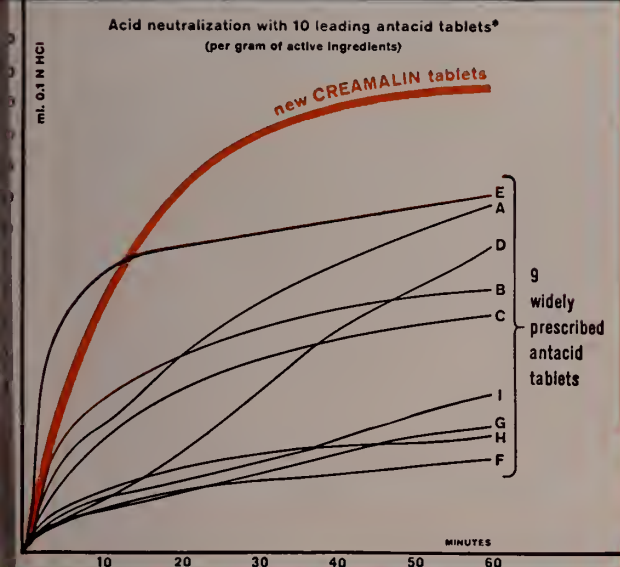
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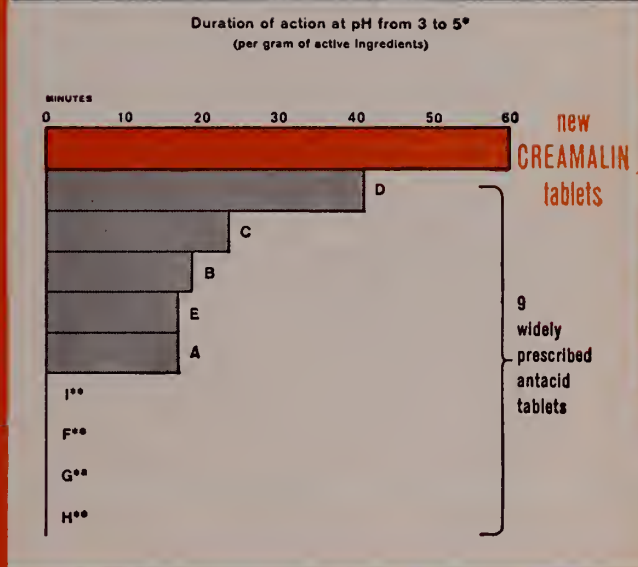
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Quicker Relief • Greater Relief



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\*Hinkel, E. T., Jr., Fisher, and Tanter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

\*\*pH stayed below 3.

Do antacids have to taste  
like chalk?



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

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
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*References:* 1. Farah, L.: *Internat. Rec. Med.* 169:379 (June) 1956. 2. Smigel, J. O., et al.: *J. Am. Geriatrics Soc.* 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: *J. Allergy* 29:358 (July) 1958. 4. Eisenberg, B. C.: *J.A.M.A.* 169:14 (Jan. 3) 1959. 5. Maryssael, L.: *Bruxelles-méd.* 33:141 (Jan. 26) 1958. 6. Pfleger, R.: *Med. Klin.* 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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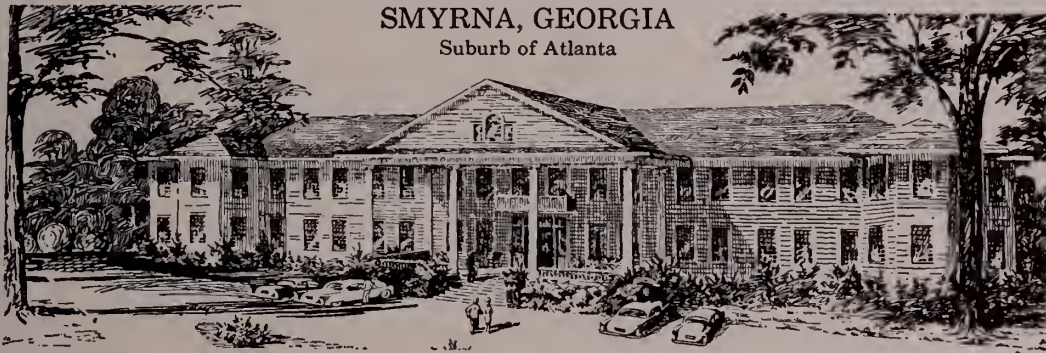
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Ralph W. Jack, Miami.....	Samuel M. Day, Jacksonville.....	Jacksonville, April 8-11, '60
Florida Specialty Societies.....			
Academy of General Practice.....	Walter J. Glenn Jr., Ft. Lauderdale	A. MacKenzie Manson, Jacks'ville	Miami Bch., Oct. 29-Nov. 1, '59
Allergy Society.....	James H. Putman, Miami.....	Ben A. Johnson Jr., Jacksonville	Jacksonville, April 8-11, '60
Anesthesiologists, Soc. of.....	George C. Austin, Miami.....	George H. Mix, Lakeland.....	Miami Beach, Oct. 4, '59
Chest Phys. Am. Coll., Fla. Chap.....			
Dermatology, Soc. of.....	Bruce M. Esplin, Miami.....	Jack H. Bowen, Jacksonville.....	
Health Officers' Society.....	Chester L. Nayfield, Winter Haven	L. L. Parks, Jacksonville.....	Jacksonville, April 8-11, '60
Industrial and Railway Surgeons.....	Lloyd J. Netto, W. Palm Beach.....	John H. Mitchell, Jacksonville.....	
Internal Medicine.....	Lawrence E. Geeslin, Jacksonville	Charles K. Donegan, St. Petersburg	Jacksonville, April 8-11, '60
Neurosurgical Society.....	W. Tracy Haverfield, Miami.....	Edward J. Sullivan Jr., Jack'ville.....	W. Palm Beach, Dec. 5-6, '59
Ob. and Gynec. Society.....	Homer L. Pearson, Jr., Miami.....	Sam W. Denham, Jacksonville.....	Jacksonville, April 8-11, '60
Ophthal. & Otol., Soc. of.....	G. Dekle Taylor, Jacksonville.....	Joseph W. Taylor Jr., Tampa.....	Jacksonville, April 8-11, '60
Orthopedic Society.....	Elwin G. Neal, Miami Shores.....	Richard A. Worsham, Jacksonville	Chicago, Sept. 1959
Pathologists, Society of.....	James B. Leonard, Clearwater.....	John A. Shively, Bradenton.....	Jacksonville, Nov. 12-15, '59
Pediatric Society.....	B. A. Dobbins Jr., Ft. Lauderdale	Camillus S. L'Engle, Jacksonville	
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Proctologic Society.....	Don C. Robertson, Orlando.....	Matthew A. Larkin, Miami.....	
Psychiatric Society.....			
Radiological Society.....	Russell D. D. Hoover, W. P. Bch.	John P. Ferrell, St. Petersburg.....	
Surgeons, Am. Coll., Fla. Chapter.....	George W. Morse, Pensacola.....	C. Frank Chunn, Tampa.....	
Surgeons, General, Fla. Assn. ....	C. Burling Roesch, Jacksonville.....	Thad Moseley, Jacksonville.....	
Urological Society.....	Edwin W. Brown, W. Palm Beach	Wm. A. VanNortwick, Jacksonville	
Florida—			
Basic Science Exam. Board.....	P. A. Vestal, Winter Park.....	M. W. Emmel, Gainesville.....	Gainesville, Nov. 7, '59
Blood Banks, Association.....	Leo L. Foster, Tallahassee.....	Wilma Holt, Pensacola.....	Clearwater, May 13-15, '60
Blue Cross of Florida, Inc.....	Mr. C. DeWitt Miller, Orlando.....	Mr. H. A. Schroder, Jacksonville	Jacksonville, Dec. 2-4, '59
Blue Shield of Florida, Inc.....	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville.....	
Cancer Council.....	Joseph J. Zavertrnik, Miami.....	Lorenzo L. Parks, Jacksonville.....	Jacksonville, April 10, '60
Diabetes Association.....	J. J. Lowenthal, Jacksonville.....	Morris B. Seltzer, Daytona Bch.....	Miami Bch., Oct. 29-30, '59
Dental Society, State.....	A. D. Farver, Miami Beach.....	Richard Chace, Orlando.....	Miami Bch., May 15-18, '60
Heart Association.....	Sidney Davidson, Lake Worth.....	Mrs. E. D. Pearce, Miami.....	Miami, April 30, '60
Hospital Association.....	Ted L. Jacobsen, Clearwater.....	Joseph F. McAloon, Hollywood.....	Jacksonville, Dec. 2-4, '59
Medical Examining Board.....	George S. Palmer, Tallahassee.....	Homer L. Pearson Jr., Miami.....	
Nurses Association, State.....	Mrs. Idalyne Lawhon, Tampa.....	Mrs. Maurine Finney, Miami.....	Orlando, Oct. 13-16, '59
Pharmaceutical Assn., State.....	Rufus Thomas, New Smyrna Bch	Mr. R. Q. Richards, Fort Myers.....	Tampa, May 15-18, '60
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Southern Medical Association.....			Dallas, Texas, Dec. 1-4, '59
Alabama Medical Association.....	Milford O. Rouse, Dallas, Texas.....	V. O. Foster, Birmingham.....	Atlanta, Ga., Nov. 16-19, '59
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Southeastern Allergy Assn.....	C. P. Wofford, Johnson City, Tenn	Kath. B. MacInnis, Columbia, S.C.	
Southeastern Surgical Congress.....	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta.....	N. Orleans, March 21-24, '60
Gulf Coast Clinical Society.....	William J. Atkinson, Mobile, Ala.....	Dan Sullivan, Mobile, Ala.....	Mobile, Ala., Oct. '59



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# County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	George H. Putnam, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	69
* Bradford, Gilchrist, Union				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	34
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	67
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	243
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	6
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* Baker				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	957
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	358
* Clay				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	116
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	242
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	36
* Sumter				
Lee-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-				
Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	81
Madison	Thomas G. Boulard Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	32
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	35
* Levy				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	9
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	243
* Osceola				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	181
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	309
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	133
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	93
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	6
* Dixie				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	102
* Flagler				
Walton-Okalooosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	34
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

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85:1081, 1957.

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**bibliography:** (1) Green, J. R., & Steelmon, H. F.: *Epileptic Seizures*, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* 23:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: *Current Therapy 1959*, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* 4:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) Lemere, F.: *Northwest Med.* 53:482, 1954. (7) Perlstein, M. A.: *Pediatr. Clin. North America* 4:1079 (Nov.) 1957. (8) Livingston, S., & Pouli, L.: *Pediatrics* 19:614, 1957. (9) Corter, C. H., & Moley, M. C.: *Neurology* 7:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* 33:105, 1958.





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1. Boland, E. W., and Headley, N. E.: Paper read before the  
Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc.,  
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## new hope for fetal salvage

## DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein<sup>1</sup> in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that in Delalutin-treated women, fetal salvage of infants below term

weight (1000 to 2000 gm.) was significant improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Fetal salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long acting.

According to Tyler and Olson,<sup>5</sup> "The qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . ."

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William Peller  
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Randy Sinis  
Denver, Colo.



Richard Miller  
Denver, Colo.



Scott Knudsen  
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H.-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

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- more effective in producing and maintaining a completely matured secretory endometrium
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- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

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enorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

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Use of its low viscosity, Delalutin may be admin-  
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tion). Complete information on administration  
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benzoate.

*These healthy, normal babies were born by a mother with a documented previous history  
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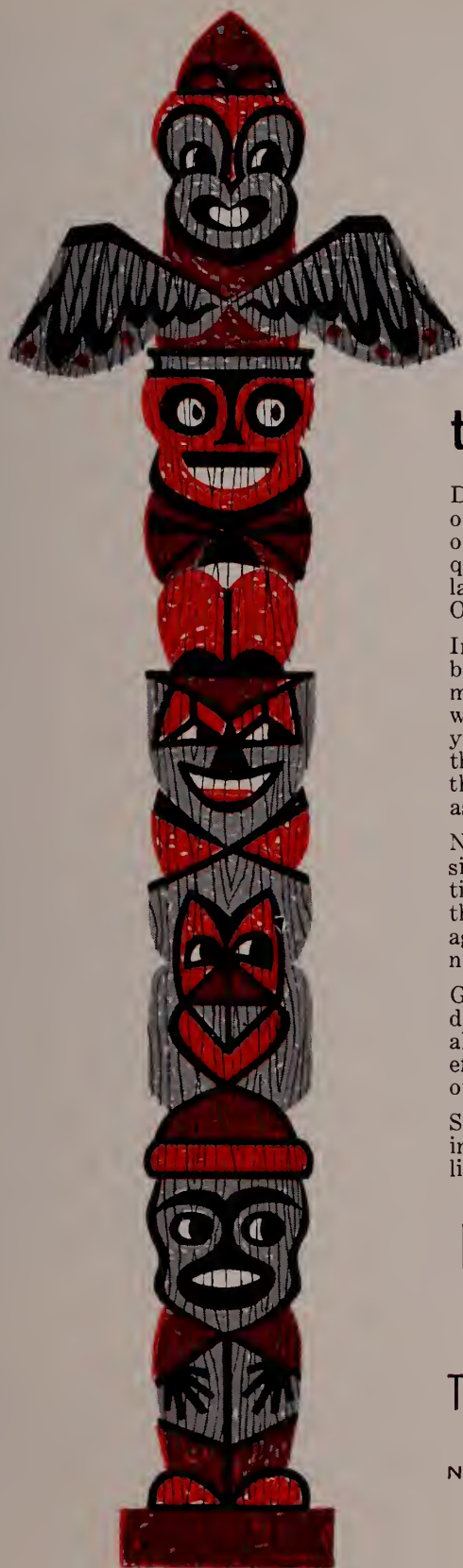
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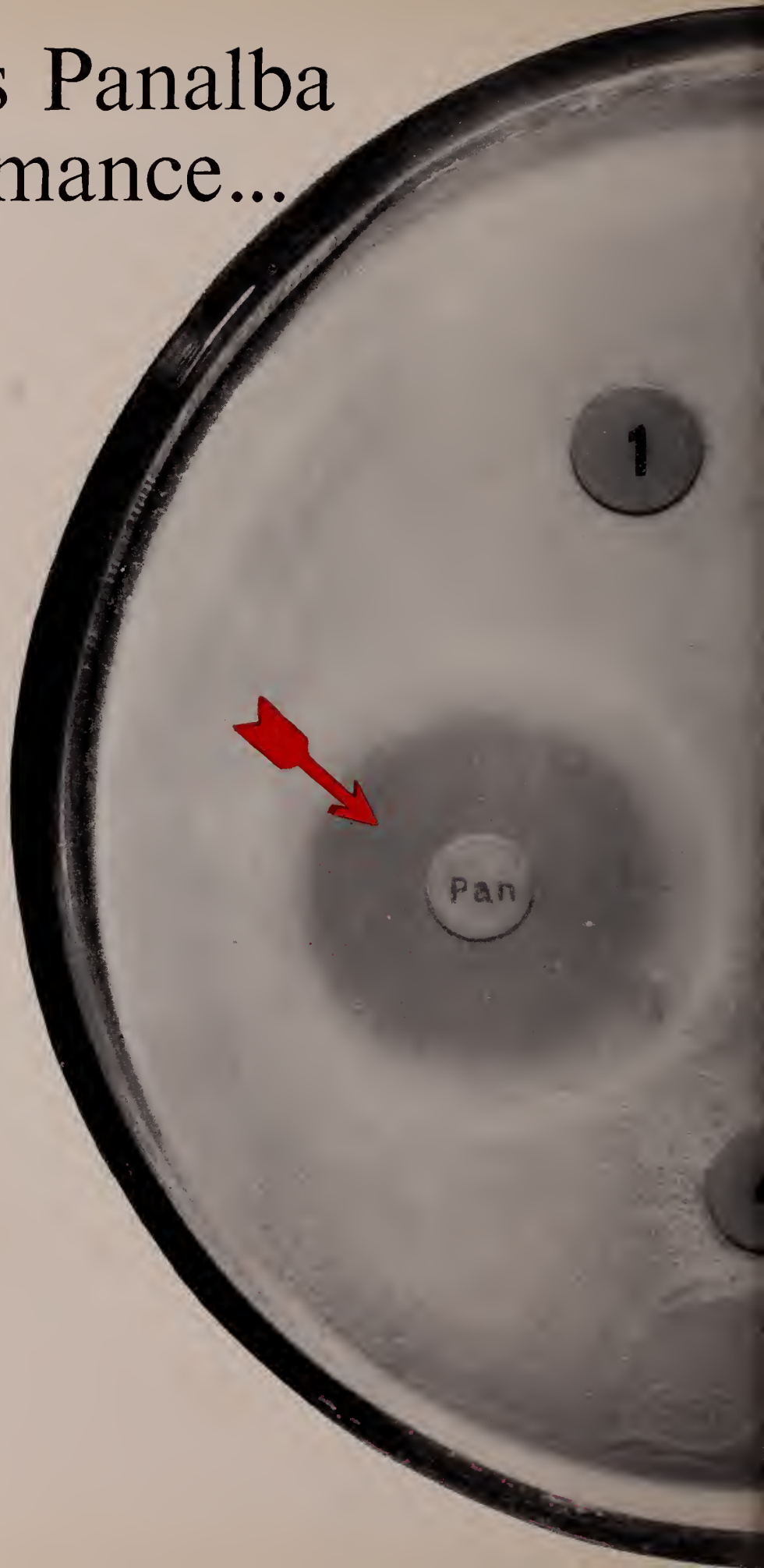
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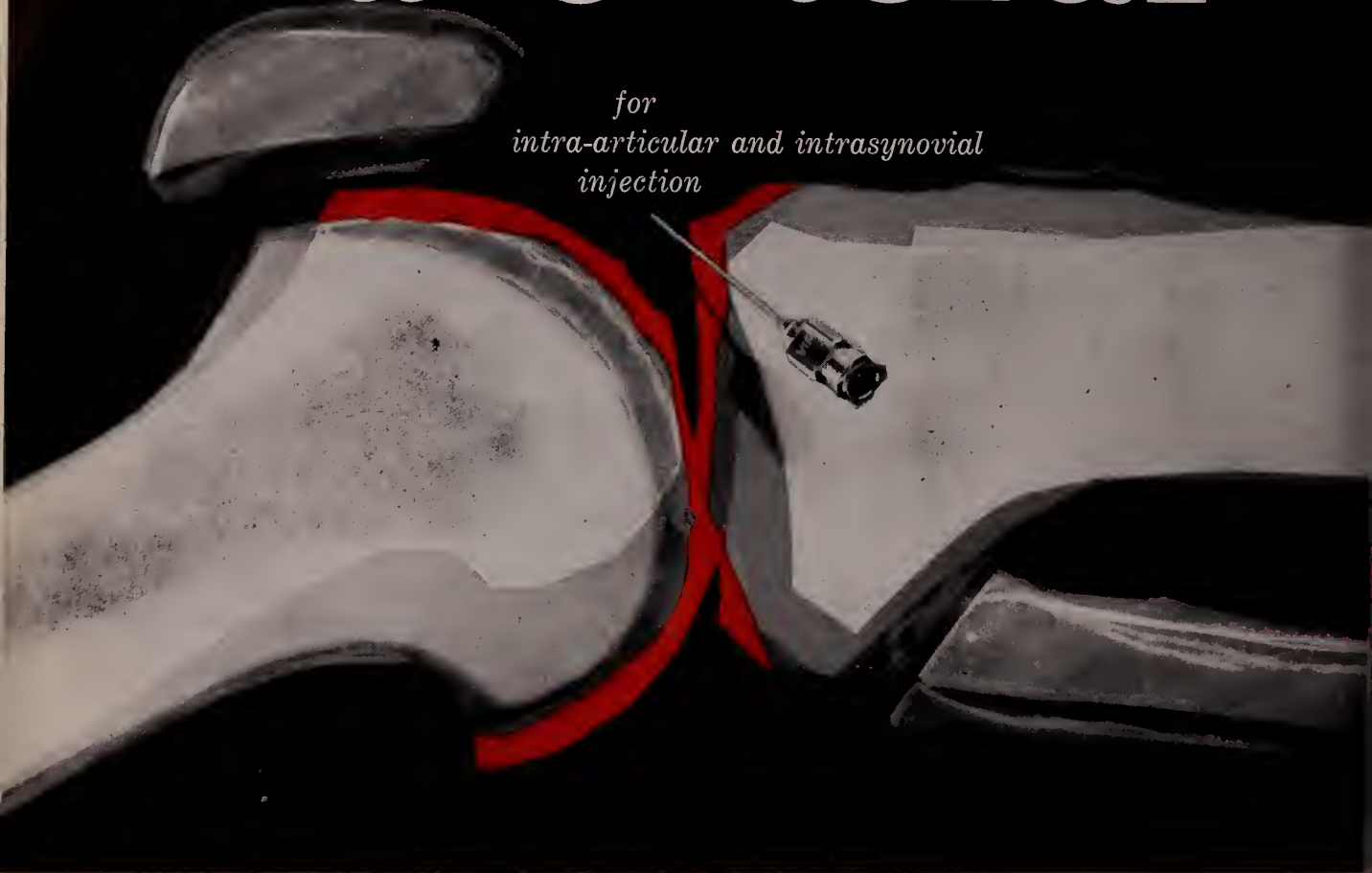


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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 4, October, 1959

## Open Cardiac Repair of Atrial Septal Defects: Analysis of Technics and Results In Twenty Cases

ROBERT S. LITWAK, M.D., FRANK T. KURZWEG, M.D.,  
JOHN J. FOMON, M.D., AND NORMAN M. KENYON, M.D.\*  
MIAMI

Atrial septal defects represent one of the common congenital cardiac defects seen in medical practice. Today, surgical correction of these anomalies is possible at relatively minimal risk. It is the purpose of this communication to review the surgical technics and results in a series of 20 patients, aged four to 49 years, operated upon at the Jackson Memorial Hospital since November 1957. All defects were closed by open cardiac repair under direct vision utilizing either hypothermia or extracorporeal circulation. In all instances the clinical impression of atrial septal defect was documented by right heart catheterization.\*\*

### Pathologic Anatomy

The intracardiac anatomy of all 20 atrial septal defects was of three posterior septum (secundum) types: (1) central defect, (2) superior marginal defect, and (3) multifenestrated membranous septal defect.

(1) CENTRAL DEFECT (Fig. 1).—This was the most common type and was seen in 15 cases (75

per cent). It is situated in the region of the fossa ovalis and may reach the orifice of the inferior vena cava and the posterior atrial wall.

(2) SUPERIOR MARGINAL DEFECT (Fig. 2).—This variant was observed in three cases (15 per cent). The defect is situated immediately subadjacent to the superior vena cava; it is often associated with anomalous pulmonary venous return from the right lung to the right atrium, superior vena cava or left anomalous pulmonary venous return into the coronary sinus or a persistent left superior vena cava. Indeed, one of the three cases did exhibit this type of defect in association with total anomalous pulmonary venous drainage from the right lung.

(3) MULTIFENESTRATED MEMBRANOUS SEPTAL DEFECT (Fig. 3).—Multiple defects of this type were observed in two cases (10 per cent).

### Indications for Surgical Closure

Any consideration of the necessity for surgical closure of atrial septal defects requires an inquiry into the natural history of the anomaly. While the prognosis for a patient with an atrial septal defect is relatively good, it must be recognized that the mean life expectancy for patients with this defect is just under 40 years. Further, we now know that it is not possible to predict when a given patient who has been totally free of symptoms may suddenly begin to deteriorate at a rapid rate. The

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Read before the Florida Heart Association, Annual Meeting, Miami Beach, May 1, 1959.

\*NIH Research Fellow HF-8748.

\*\*Physiologic studies were performed under the direction of Drs. Philip Samet (Mount Sinai Hospital, Miami Beach), Francisco A. Hernandez (National Children's Cardiac Hospital) and Leonard S. Sommer (Jackson Memorial Hospital).

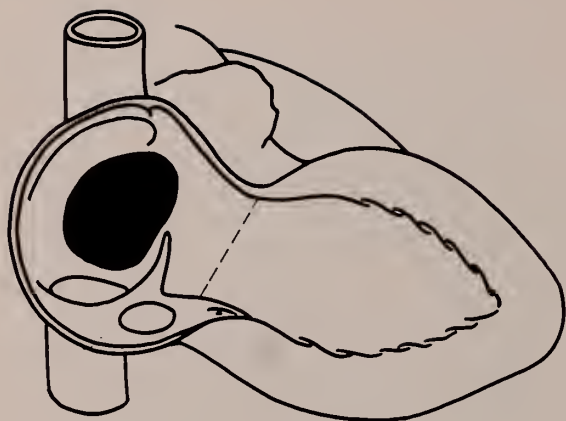
**CENTRAL DEFECT****15 CASES**

Fig. 1.—Central type of atrial defect. This type occurred most frequently (75 per cent of cases).

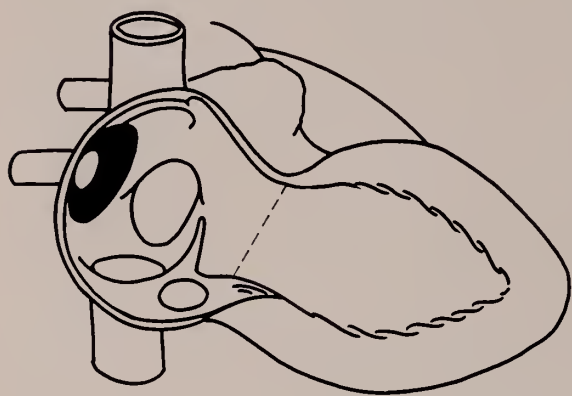
**SUPERIOR MARGINAL DEFECT****3 CASES**

Fig. 2.—Superior marginal defect (three cases). Frequently, this type is associated with anomalous pulmonary venous connections and drainage.

devolutionary patterns seen in these patients result from (1) the pronounced left to right shunt, or more commonly (2) the development of severe pulmonary hypertension with ultimate reversal of the shunt. In the former instance, the large left to right shunt at the atrial level is associated with large pulmonary blood flows often several times that of the calculated systemic flow. Despite this increase the pulmonary vascular resistances and the pulmonary arterial pressures are relatively low. The magnitude of the shunt alone results in extreme right heart dilatation and ultimate cardiac failure.

In the second group of cases, those manifesting severe pulmonary hypertension, cardiac failure develops as a result of a different mechanism. Here, the relative severity of the lesion is largely governed by the presence of extensive obliterative changes in the muscular arteries of the lung. These pulmonary vascular changes produce a significant degree of pulmonary and right ventricular hypertension. With this increased resistance to flow, the right ventricular end diastolic pressure eventually rises as does the right atrial pressure. The left to right shunt now either diminishes or may become balanced or even reversed.

In view of the rather limited prognosis and the unpredictable propensity for the development of severe pulmonary hypertension, corrective surgical measures are considered in any patient having a proved atrial septal defect with a large left to right shunt. The presence or absence of symptoms was not used as a criterion for surgical treatment in this series since all patients had either large left or right shunts or significant pulmonary hypertension on cardiac catheterization.

Surgical closure of the defect is contraindicated in any patient whose pulmonary vascular resistance is so high that the shunt at the atrial level is balanced or reversed. Such a patient is no longer operable, at least in the light of present knowledge.

#### Operative Techniques

All patients in whom an uncomplicated secundum atrial septal defect was suspected were operated upon by hypothermia with coronary perfusion (18 cases). In two cases in which there was a suspicion of anomalous pulmonary venous connections and drainage associated with atrial septal defect, corrective surgical therapy was carried out utilizing extracorporeal circulation.

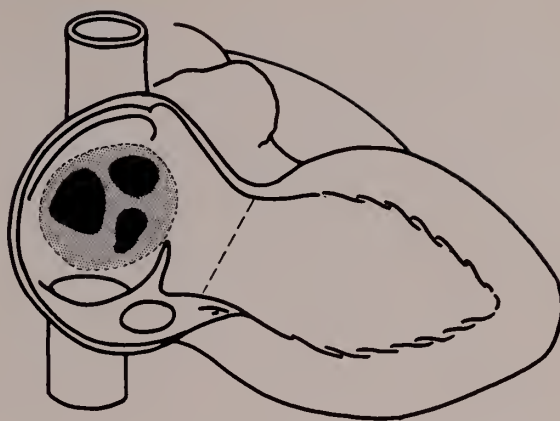
1. HYPOTHERMIA AND CORONARY PERFUSION.—Choice of hypothermia with inflow (caval) and outflow (aorta and pulmonary artery) occlusion for the repair of uncomplicated defects of the atrial septum is based upon our experience that it is a simple and safe method for the performance of open heart surgery provided that the total intracardiac operating time is less than seven minutes. The widespread acceptance of this modality is in large measure due to the basic investigations of Bigelow<sup>1-3</sup> and Hegnauer<sup>4,5</sup> and the clinical reports of Lewis<sup>6,7</sup> and Swan.<sup>8</sup>

A brief outline of the hypothermic technic utilized for the 18 cases of atrial defect in which

the operation was performed by that means follows.\*

The patient is anesthetized with Pentothal Sodium, nitrous oxide and D-Tubocurarine. The esophageal temperature is lowered to approximately 86 F. (30 C.) by external cooling. The heart is exposed through a bilateral transsternal thoracotomy, and a preliminary exploration of the cardiac chambers is carried out by insertion of a finger through the right atrial appendage. The relative size and position of the defect are appraised and the precise technic of operative repair decided upon prior to the period of circulatory arrest. Preparations are now made to carry out the repair of the defect through a right atriotomy. The superior and inferior vena cavae are looped with umbilical tapes which are fed through lengths of rubber tubing. A catheter is inserted into the aorta just distal to the coronary ostia. This is connected with a bottle of arterialized, heparinized blood warmed to 98.6 F. (37.5 C.) Open cardiac repair is accomplished by inflow (caval) and outflow (aorta and pulmonary artery) occlusion. The right atrium is opened widely to expose the septal defect in a bloodless field. The defect is closed with a running suture of cotton reinforced with several interrupted sutures. During the period of circulatory arrest coronary perfusion is accomplished via the catheter inserted into the aorta (fig. 4).<sup>9,10</sup> The right side of the heart is refilled with blood by temporarily releasing the superior vena caval tape and the right atrial incision is clamped. Circulation is re-established by release of the outflow occluding clamp followed by caval tapes. The atrial incision is then repaired and the coronary perfusion catheter removed from the aorta. The average period of circulatory occlusion has approximated five minutes. The chest is closed and rewarming begun. Return to normal temperature is attained in two to three hours.

**2. EXTRACORPOREAL CIRCULATION.**—In two cases of atrial septal defect in which complicating anomalous pulmonary venous connections and drainage were suspected repair was accomplished with the pump-oxygenator rather than hypothermia. This course was elected in view of the possibility that the intracardiac repair would be more time-consuming than for the usual uncomplicated atrial septal defect. The heart-lung machine in clinical use at the Jackson Memorial Hospital is a Gibbon type stationary vertical



MULTI-FENESTRATED MEMBRANEOUS SEPTUM

## 2 CASES

Fig. 3. — Multifenestrated septal defect of secundum variety (10 per cent of cases).

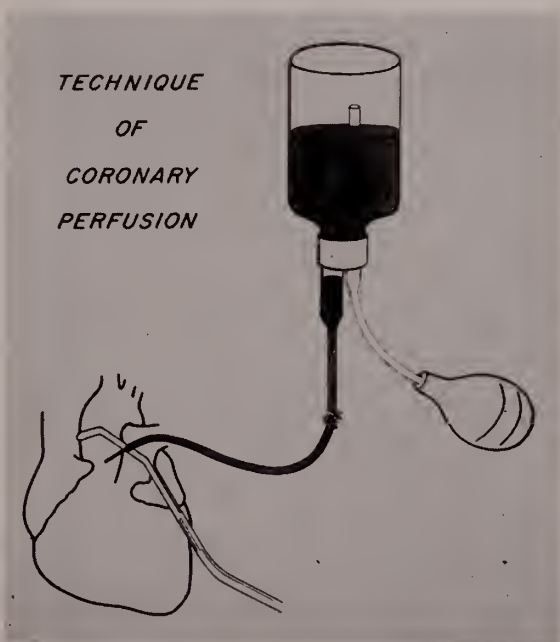


Fig. 4. — Technic of coronary perfusion utilized during hypothermic circulatory arrest.

screen oxygenator with three roller semiocclusive pumps (fig. 5). Total body perfusion is accomplished by diverting the caval flow to the machine and returning the oxygenated blood to the patient via the left femoral artery. Cardiac repair is performed through a wide right atriotomy.

In one of the two patients operated on with the aid of the heart-lung machine, no abnormality other than the atrial defect was present, and this was closed by direct suture. In the second case, total anomalous pulmonary venous connections

\*Hypothermia and anesthesia were conducted by Drs. Sanford Cobb and J. Gerard Converse.



from the right lung were associated with the atrial septal defect (fig. 6a). The right superior pulmonary vein inserted into the superior vena cava, and the inferior pulmonary vein entered the right atrium. A Teflon patch was inserted in a fashion which both directed the right pulmonary venous flow through the septal defect into the left atrium and reconstructed the atrial septum in a manner which completely separated the two atrial circulations (fig. 6b).

#### Operative and Postoperative Complications

The only major operative complication encountered was that of cardiac arrhythmias. These occurred only in the cases in which the patient

was operated on under hypothermia. Atrial arrhythmias were commonly observed, but these invariably disappeared during rewarming. Ventricular fibrillation occurred three times. On two of the three occasions it developed before the cardiac repair was performed. Reversion to sinus rhythm was easily accomplished by electric defibrillation, following which the operative repair was completed in both cases. In the third case, ventricular fibrillation ensued immediately after intracardiac repair and this was again successfully treated by electric defibrillation. All three patients survived and are alive and well.

During the rewarming phase a moderate acidosis (combined metabolic and respiratory) is

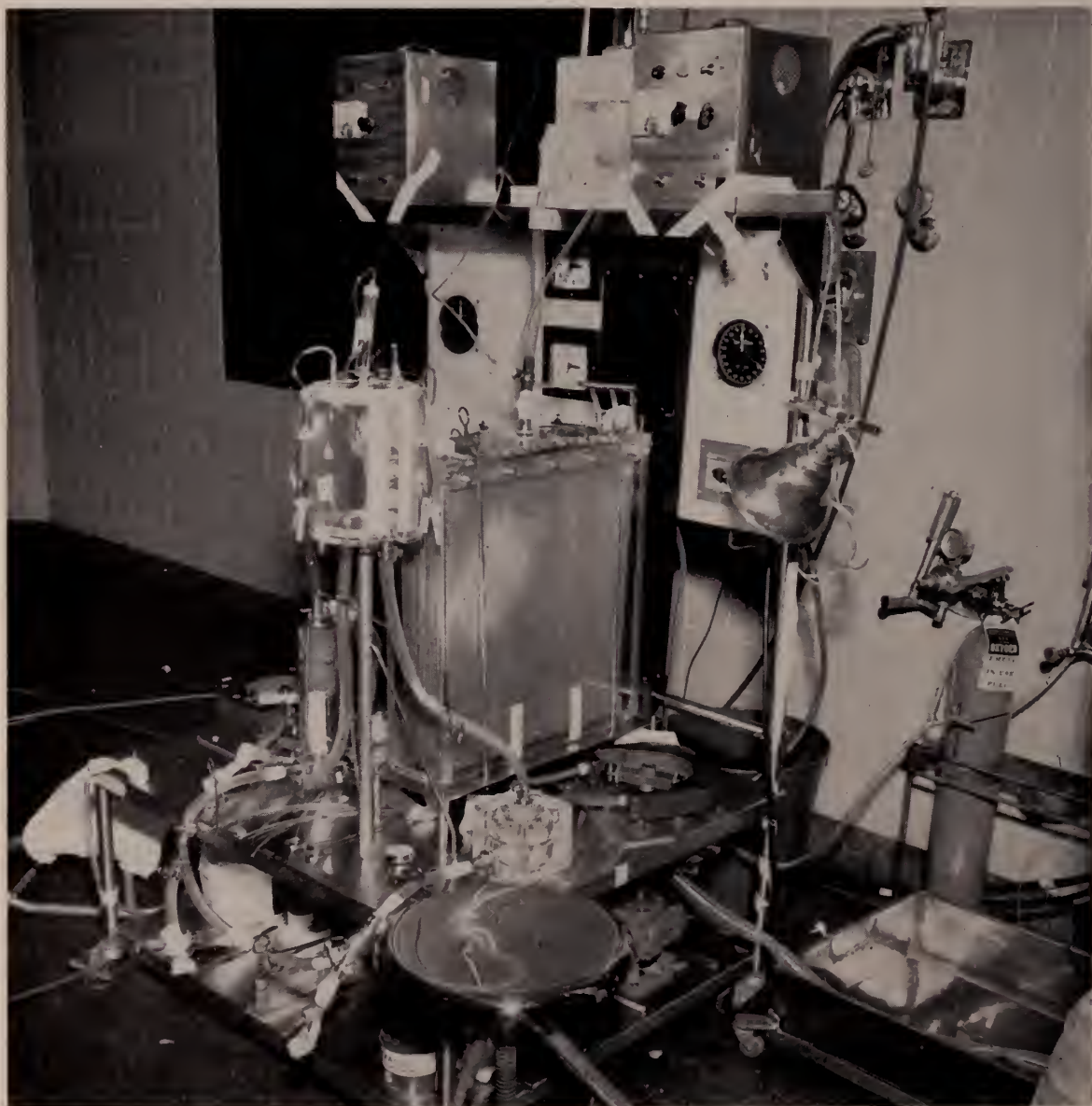


Fig. 5. — Photograph of Gibbon type stationary vertical screen heart-lung machine in clinical use at the Jackson Memorial Hospital.

frequently observed. On rare occasions small amounts of intravenous sodium bicarbonate have been used to combat the acidotic state. In the majority of patients, however, no additional base has been administered. Invariably the pH has returned to normal by the eighth postoperative hour.

Postoperative complications have been gratifyingly few. The single major complication encountered has been the development of supraventricular arrhythmias in five patients (25 per cent.) In three of them nodal rhythm developed, and in two additional patients atrial flutter developed. Sinus rhythm has been restored in all but one patient within two months following the operation. One patient has recurrent bouts of atrial flutter.

### Clinical Results

Nineteen of the 20 patients are alive and well (5 per cent mortality). The only death in this series occurred in a 42 year old woman who underwent an apparently routine closure of an atrial defect under hypothermia with coronary perfusion. She was returned to the recovery room where she was noted to be awake and completely alert. Eight hours after the operation, however, sudden circulatory arrest occurred. Resuscitative measures were attempted without success. At necropsy, a large anteroseptal infarct was found of approximately six to eight weeks' duration. Although the precise cause of death is still uncertain, it is probable it was a sudden ventricular arrhythmia which was evoked by the large infarct.

Clinical improvement in all the patients has been striking. In the 11 patients who had a preoperative history of dyspnea and fatigue, all but two are asymptomatic even on exercise. These two patients, who were in severe cardiac failure prior to the operation, are now asymptomatic in performance of their usual daily tasks, but have not attempted any heavy exercise since the operation.

It is of interest that six of the eight patients who were apparently symptom-free before the operation have exclaimed that in retrospect their exercise capacity was indeed limited in view of the decided increase in capacity they experienced following cardiac correction.

Changes in physical findings following closure of the defects in all 19 surviving patients were fairly consistent. The precordial "heave" seen so commonly in these patients was uniformly absent. Systolic thrills invariably disappeared in

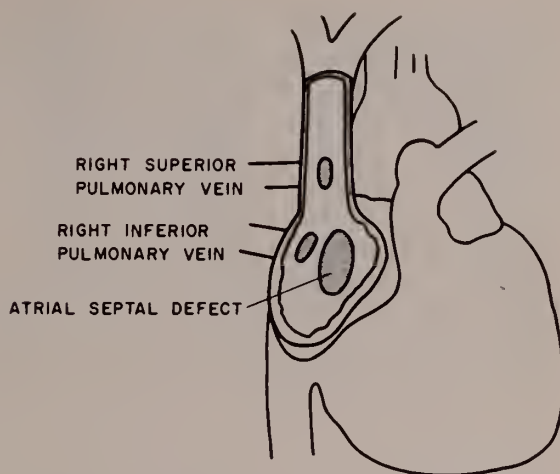


Fig. 6a. — Total anomalous pulmonary venous connections and drainage from the right lung associated with a superior marginal atrial defect.

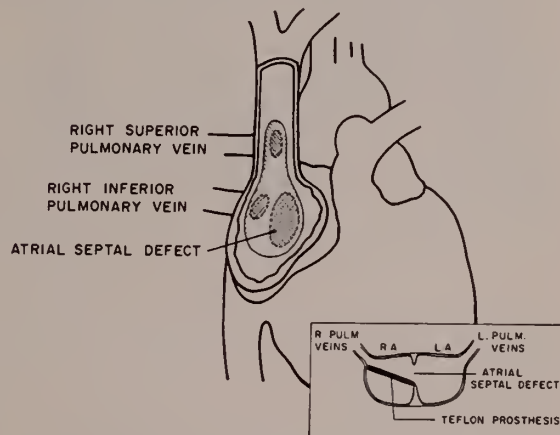


Fig. 6b. — Technic used to repair anomaly pictured in 6a. A Teflon patch has been inserted so that the right pulmonary venous drainage is diverted through the atrial defect. The atrial septum has been reconstructed in a manner which completely separates the two atrial circulations.

all patients presenting this finding preoperatively. Pronounced diminution or complete absence of the precordial systolic murmur occurred in every patient. In two cases, persistence of a faint systolic murmur can probably be ascribed to tricuspid insufficiency which was detected at operation. Three other patients who were discharged following operation with faint systolic murmurs were found to have no auscultatory abnormality whatsoever at the time of their six month follow-up visit. It is probable that residual systolic murmurs are most commonly due to relative narrowing of the pulmonary valve at the annulus in comparison to the enormous size of the pulmonary artery trunk. This discrepancy results in turbulence which, in turn, produces the murmur.<sup>8</sup> With



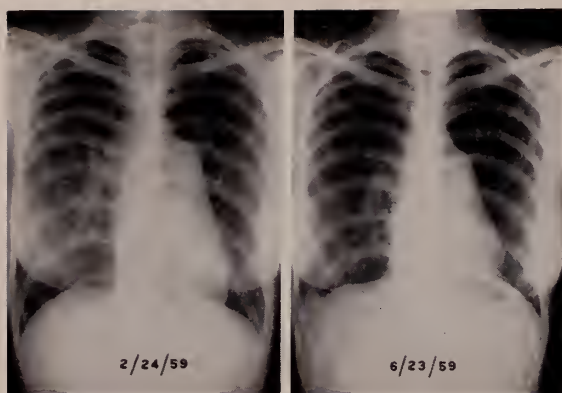


Fig. 7.—Comparative preoperative and postoperative roentgenograms of patient whose lesion was illustrated in figures 6a and 6b. Note significant diminution in size of cardiac silhouette and pulmonary vasculature approximately four months after operation.

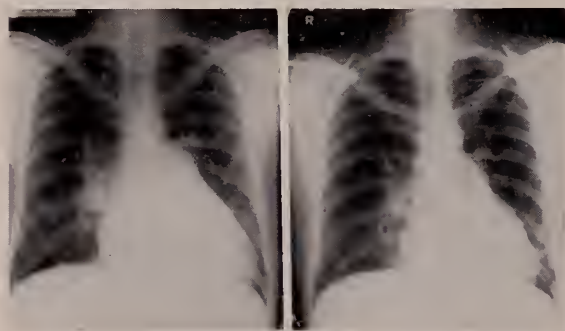


Fig. 8.—Comparative preoperative and postoperative roentgenograms of a 47 year old patient who had been in frank cardiac failure before closure of the atrial defect. The roentgenogram on the right was taken four months following operation.

the diminution in size of the pulmonary artery trunk in the months after surgical correction, the turbulence distal to the pulmonary valve annulus diminishes as does the murmur.

Postoperative radiologic examinations have revealed significant regression of cardiac size and pulmonary vascularity (figs. 7 and 8). On fluoroscopy, the previously bounding pulmonary artery trunks have been significantly less pulsatile.

Closure of the defects has been documented in a small number of cases by postoperative cardiac catheterization. These and other clinical data will be reviewed in detail in another communication.<sup>11</sup>

### Summary and Conclusions

Experience with 20 cases of secundum type atrial septal defects is described with special reference to pathologic anatomy and surgical technics.

In 18 cases surgical closure of the defects was accomplished by hypothermia with one death. In two cases of atrial defects in which complicating anomalous pulmonary veins were suspected, the operation was performed by extracorporeal circulation without mortality. Thus the over-all operative mortality (hypothermia and extracorporeal circulation) is 5 per cent.

The single major postoperative complication encountered was the development of supraventricular arrhythmias in five cases. Sinus rhythm was subsequently restored in all but one case within two months following the operation.

Striking clinical improvement in all patients has been observed. Great subjective improvement has been substantiated by objective data. The latter consist of rapid diminution of cardiac size and loss of precordial cardiac thrust and murmurs.

In view of the relatively low operative risk, open cardiac surgical correction of secundum type atrial septal defects is recommended in all patients with proved atrial septal defects and a large left to right shunt.

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# A Review of 1,150 Consecutive Tonsillectomies And Adenoidectomies With a Glance At the Literature

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The primary purpose of this paper is to review 1,150 consecutive tonsillectomies and adenoidectomies with particular reference to the incidence of postoperative bleeding, preoperative medication and anesthesia. This study is compared with similar studies.

## Historical

Upon searching the literature I found it was difficult to obtain specific historical data on tonsillectomies and adenoidectomies.

Although Physick had devised a tonsillotome in 1825, surgeons were afraid of hemorrhage during and after tonsillar operations and were prone to resort to ligation of the base of the tonsil with heavy catgut or silver wire. The slicing tonsillotome of Mackenzie came into use during the '70s, and was not displaced by the snare, by scissors or by the LaForce and Sluder tonsillotomes until this century. While adenoids were noted by Meyer of Copenhagen in the '60s, American otolaryngologists paid little attention to them for many years.

## Indications

I am sure that at times every otolaryngologist has the impression that he is probably advising an excessive number of tonsillectomies and adenoidectomies. Not infrequently he will advise four or five tonsillectomies and adenoidectomies in succession, and I am sure that those in his office at such a time think that his only indication for the removal of the tonsils and adenoids is that they are present. It must be remembered, however, that tonsillectomies and adenoidectomies are a definite part of his practice and parents having children needing tonsillectomy and adenoidectomy will naturally gravitate to his office. The great majority of these parents have been advised to have their children's tonsils and adenoids removed long before the children are seen by the otolaryngologist.

Fortunately, today many patients are referred by pediatricians with the request that tonsillectomy and adenoidectomy be performed. Usually there is a note stating the child has had repeated attacks of tonsillitis, otitis media, cervical adenitis, rheumatic fever, complete nasal obstruction, or other conditions which otolaryngologists all agree are absolute indications. The mother usually states that the pediatrician believes the child's tonsils and adenoids should be removed; however, she would like for the final decision to be left entirely to us. I seriously doubt if there are many of us who put up much resistance to this type of approach. Occasionally, the question arises regarding performing an adenoidectomy only. In the past I have been embarrassed by having a child back two or three years later with what I consider absolute indications for a tonsillectomy. The family have usually forgotten the decision which preceded the adenoidectomy and are only interested in the additional expense and inconvenience of another operation. This conversation usually culminates in their advice that most nose and throat specialists take out the tonsils when they remove the adenoids, and they suggest that in the future it would be well to adhere to this principle. The question of operative fee never fails to enter into this conversation, and they seldom fail to suggest a reduction of the operative fee. Notwithstanding, I still see patients in whom I think that adenoidectomy alone is indicated. I am, however, probably more reluctant than I should be in advising adenoidectomy alone.

There are many indications listed in the literature, but those set forth by McLaurin and Raggio are as comprehensive as any I have found: 1. Frequent attacks of tonsillitis with fever and other systemic manifestations. These authors qualify this indication by favoring removal "when the tonsils and adenoids have lost their protective properties and have themselves become overwhelmed by infection." This statement is a wonderful way to explain the reason for a tonsillec-

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President's address, Nineteenth Annual Meeting of the Florida Society of Ophthalmology and Otolaryngology, Miami Beach, May 11, 1958.

tomy and adenoidectomy to the parents, but in the seclusion of my closet I have to admit that I have no precise way of telling when the tonsils have lost their protective properties and when they are overwhelmed by infection. In fact, I have my serious doubts that the pathologist after studying serial sections would venture an opinion. 2. Recurrent peritonsillar abscess. My comment regarding this indication would be that one attack of quinsy is sufficient for me to advise tonsillectomy, and this advice also applies to Vincent's angina of the tonsil. 3. Frequent infections of the ear whether they are suppurative or serous. There have been a number of studies of conductive deafness of children, and enlarged adenoids have been found to be the cause in a high percentage of cases. Also, in a high percentage of cases the hearing has been restored following tonsillectomy and adenoidectomy. 4. Persistent and recurrent cervical lymphadenopathy, though only after other possible causes have been ruled out. 5. Difficulties in speech, breathing and swallowing when they are of obstructive origin and are caused by excessive hypertrophy of the tonsils and adenoids. 6. Diphtheria carriers.

These authors added two more indications which they thought might be debatable: 7. Frequent or continuous head colds. 8. Failure to gain weight and lack of general well-being. In this category I should like to add foci of infection and hygiene.

Occasionally, one sees huge cryptic tonsils with the crypts filled with foul-smelling debris. I think that, particularly in young people, these tonsils should be removed, but I have placed this indication in the debatable category.

### Laboratory Studies

In an effort better to understand the phenomenon of hemorrhage following tonsillectomies and adenoidectomies, several careful studies have been undertaken. The former theories of blood coagulation for the most part have been discarded as inadequate. Morawitz's theory is:

1. Prothrombin + Thromboplastin + Calcium = Thrombin
2. Thrombin + Fibrinogen = Fibrin (clot)

This theory sounds reasonable, but leaves much to be desired. It is now thought that there are three distinct phases in the coagulation of blood: (1) the activation of thromboplastin; (2) the formation of thrombin; and (3) the production of fibrin.

The dynamics of the process is of great importance. Alexander emphasized this fact by saying, "Dormant and yet delicately poised in the circulating blood, the process is triggered, then assuming ever-increasing velocity wherever a break in vascular integrity occurs until a final goal of hemostasis is achieved. The importance of emphasizing dynamics, rather than quantity, is clearly illustrated by the fact that large and voluminous clots may form but simply not fast enough." There is then a most important function of the vascular system in hemostasis, which is not as well understood as is the coagulation of shed blood. It is surely on this basis that Richards stated, "The results of tests of bleeding and clotting time are highly misleading in respect to postoperative hemorrhage following T & As." He added, "The omission of clotting and bleeding time in an otherwise normal patient cannot be regarded as negligence or inadequate pre-operative preparation." The literature reveals that most surgeons require coagulation and bleeding tests and urinalysis, and many include a complete blood count.

Coyle, who wrote an excellent thesis on this subject, recommended the following preoperative test for tonsillectomies and adenoidectomies: (1) complete blood count, (2) bleeding time, (3) coagulation time, (4) capillary fragility test, (5) clot retraction test, and (6) prothrombin time. The price of this battery of tests at the laboratory I use would be \$21, and with urinalysis \$24. Although Coyle recommended this battery of tests, he also stated that the results of all of these tests may be normal and still the child may have a severe postoperative hemorrhage. A number of cases have been reported in which severe bleeding occurred in patients with unsuspected conditions such as pheochromocytoma, which was recently encountered in Orlando. In this case there was no rhyme or reason to the patient's bleeding, and it was only controlled after both external carotid arteries were ligated. The unstable blood pressure made a physician suspicious and led to the diagnosis.

I find that most of the parents of my patients are cognizant of the possibility of bleeding following tonsillectomy and adenoidectomy and are fluent in giving a history of any bleeding in their child or family. Even though I think some mention should be made of bleeding, I have never been able to correlate the history of bleeding for a long time after cutting fingers and so forth with the incidence of postoperative hemorrhage. I



have now come to believe that when a mother goes into great detail concerning her child being a free bleeder, this is the child who surely will not bleed.

In the future, laboratory tests may tell which child will bleed following a tonsillectomy and adenoidectomy, but for the present these tests are practically useless in this regard. Nevertheless, I suppose one should continue ascertaining coagulation and bleeding time.

In my series of cases, the following laboratory procedures were considered routine: (1) urinalysis; (2) coagulation time; (3) bleeding time; (4) red blood cell count; and (5) hemoglobin estimation.

### Preoperative Medication

There is considerable variation in preoperative medication in respect to coagulants. Many surgeons recommend vitamin K for a week preceding tonsillectomy and adenoidectomy. Others recommend C.V.P., some recommend vitamin C, and quite a number recommend vitamin K, C.V.P. and vitamin C. Several have reported lower incidence of postoperative bleeding following preoperative medication with vitamin K, C.V.P. and vitamin C. Most of the reports, however, cover a small series of cases and are not at all conclusive. In my series of cases, preoperative medication for the older children consisted of 5 grains of calcium lactate three times a day for a week preceding the tonsillectomy and adenoidectomy and for the younger children 1 dram of Neo-Calglucon syrup three times a day for a week. The rationale of giving calcium was based on the fact that a study, a number of years ago, revealed that children in Florida generally showed a low blood calcium. More recent studies of the coagulation of blood, however, reveal that calcium is rarely low enough to inhibit coagulation. It is admitted that calcium is a necessary component in the coagulation phenomenon and that it would be possible to have a calcium content low enough to inhibit coagulation of blood.

### Anesthesia

Before consideration is given to the type of anesthesia to be used in tonsillectomies and adenoidectomies, something should be said regarding preoperative medication. Some surgeons give atropine and morphine. Some give atropine alone, some give scopolamine and morphine, and some give scopolamine alone. Atropine and scopolamine are both good cholinergic blocking agents. Most

anesthesiologists regard atropine as superior, and it is a bottle of atropine and not scopolamine that they keep their needle in, in the operating room, for an emergency. Many of them think that scopolamine is superior as a drying agent, and of course they all agree that the amnesia effect of scopolamine is desirable.

During the past eight years some anesthesiologists in Orlando have used rectal Pentothal Sodium in tonsillectomies and adenoidectomies to induce anesthesia, while others have looked on the procedure with disdain. The dose that has been used is actually one half of the recommended dose and less than any I have found reported in the literature. My associates and I use the 10 per cent solution and give 1 cc. per 10 pounds of body weight. Others give 1 cc. per 7.5 pounds of body weight and have reported no trouble. Today, all of the Orlando anesthesiologists give rectal Pentothal Sodium, and to my knowledge to date there have been no untoward reactions. I took the liberty of collecting 1,187 cases of tonsillectomy and adenoidectomy in which Pentothal Sodium was administered rectally, and this number does not include all the cases.

What are the advantages? (1) The child in most instances goes to sleep in the room with the mother close at hand. (2) There is no induction fight. Let us face it, for in spite of the vocal preparation that some anesthesiologists so expertly administer, nevertheless in a high percentage of cases there is that final manual restraint accompanied by blood-curdling screams that penetrate the entire hospital floor. (3) Induction is smoother and faster. There is less laryngeal spasm. (4) Less ether is used. (5) Reaction time is somewhat prolonged, and this delay can be an advantage if it becomes necessary to take the child back to the operating room. (6) Less postoperative nausea and vomiting occur. It has been only during the last five years that I have had a number of mothers call me and voice apprehension because their child had not vomited. They stated that their other children had vomited when they had their tonsils and adenoids removed and they thought that all children were supposed to vomit following this procedure. I do not know to what degree this drug lowers the incidence of nausea and vomiting, but I can say that on several mornings I have had as many as eight tonsillectomies and adenoidectomies without one patient vomiting, and others using rectal Pentothal Sodium have had the same experience. Parents



whose children have had tonsillectomies and adenoidectomies with anesthesia induced by rectal Pentothal Sodium insist that subsequent children have it.

The disadvantages are: (1) A drug is being given which is not absolutely necessary. (2) A drug is being given which cannot be withdrawn. (3) Pentothal Sodium depresses the respiratory centers. (4) The drug does not abolish the pharyngeal reflex. This factor might be listed as an advantage as one certainly does not want the pharyngeal reflex abolished when the child is reacting. (5) The vasomotor center is depressed, and there is a fall in blood pressure. (6) Unnecessary time is consumed. Regarding this last disadvantage, I find, in the literature, that a number of surgeons order a cleansing saline enema the evening before surgery; however, I do not, and I have had few children evacuate on the table or in the room following the use of Pentothal Sodium. It has also been my experience that one can actually operate on more children when they are given Pentothal Sodium rectally than when it is not used. With the exception of the last, I think that these are all valid reasons for not using rectal Pentothal Sodium and I believe that they become even more so when Pentothal Sodium is given intravenously.

The fact that Pentothal Sodium is a hypnotic and not an anesthetic agent should be kept in mind always, whether it is given to children or adults. In adults, it should be supplemented with local instillation and infiltration.

The question of intubation for tonsillectomies and adenoidectomies is very much alive today, and I have reviewed some interesting papers pertaining to this subject. In 1951 Baron and Kohlmoos reported the results in 80 consecutive cases in which endotracheal anesthesia was used. Among them were eight cases of laryngeal obstruction with two deaths and seven cases of laryngeal granuloma; thus, in 18 per cent of the cases laryngeal sequelae followed endotracheal anesthesia. This was an alarming report and it stimulated a number of excellent articles on the subject. In 1953 Pender and Hallberg reported 1,050 cases in which endotracheal anesthesia was employed for tonsillectomies and adenoidectomies in children less than 15 years of age without a single untoward result.

Anesthesiologists all agree that endotracheal intubation requires the service of a trained anesthesiologist. This is a real disadvantage for the

procedure when one considers that only 20 per cent of anesthetics in this country are administered by anesthesiologists and only 50 per cent by personnel who have had formal training in anesthesiology. Recently in Orlando a patient who was intubated expired on the table, and the surgeon noted emphysema in the neck. This intubation was not performed by a trained anesthesiologist. The anesthesiologists advocating intubation recognize this shortcoming and most of them state that the next safest method of maintaining an airway in tonsillectomies and adenoidectomies is with the Crow-Davis mouth gag in head down position with the patient in at least a 15 degree Trendelenburg position. Incidentally, as Hollinger pointed out, it requires a 15 degree Trendelenburg position to place the trachea horizontally; so actually it should be greater than 15 degrees to avoid aspiration.

None of the Orlando anesthesiologists intubate routinely for tonsillectomies and adenoidectomies. Some of them intubate adults; others do not. There is never any question on the surgeon's part, as far as I know, regarding which patients are intubated and which are not. The anesthesiologists in Orlando are well qualified, and the decision is left entirely to them.

I have found the nasal tube to be the most satisfactory from a technical standpoint in adults and the oral tube in children. I have used the Barton blade with the special tube for the intubation tube and I have found it even more in the way than the oral tube. I can at least move the oral tube from side to side. This may be due to the fact that I hold my forceps, as someone said, upside down.

To sum up the discussion of anesthesia for tonsillectomies and adenoidectomies, I might quote one of the anesthesiologists, who said, "Anesthesia for T & As is in a state of flux in this country today."

**Table 1.—Types of Anesthesia Used in Series Reported**

	Number of Cases
Rectal Pentothal Sodium + Vinethene and ether (10% — 1.0 cc./10 lb.)	385
Vinethene and ether	1,035
Intravenous Pentothal Sodium + local	175
Local	6
Intubated	? (rare)

#### **Incidence of Postoperative Hemorrhage**

Those writing on postoperative hemorrhage universally refer to primary and secondary hemorrhages. The majority refer to a primary hemor-

rhage as any hemorrhage occurring within 24 hours after the operation and secondary hemorrhage as any hemorrhage occurring at any time after the 24 hour period has elapsed, but all agree that more than half of the secondary hemorrhages occur on the sixth to eighth day. The cause of the primary hemorrhage is usually vascular; it is not due to any deficiency of the blood itself as most of the studies show no such deficiency exists. Some authors think that capillary fragility tests preoperatively might give an index of the probability of primary postoperative hemorrhage. Others, however, have been unable to correlate the findings in such studies with the incidence of primary bleeding.

Several authors believe barometric pressure is an important factor. In fact, one surgeon calls the weather bureau the morning he is performing tonsillectomies and adenoidectomies. Not long ago a local epidemic of primary bleeding began shortly after two explosions on the sun. The laboratory next door was picking up a cosmic background approximately five times above normal and, incidentally, looking all over my office for radium. The following day the explosion was announced in the paper, and the next day the blood began to flow and continued for two weeks. I am sure that during this period the incidence of primary hemorrhage in my cases was about 50 per cent, and my colleagues were having the same experience. Early in April there were several huge explosions reported on the sun, and following these explosions there was no increased bleeding either in my patients or in my colleagues' patients.

Several authors attribute primary hemorrhage to rough dissection whereas others believe that rough dissection liberates certain juices from muscle tissue and tends to lessen primary hemorrhage. I cannot help but believe that careful dissection is a good surgical principle and should be adhered to in tonsil and adenoid surgery. Clamping and ligating bleeding vessels I believe is also an approved technic. The leaving of clamps of various types on vessels for a given period of time and removing them without ligating has never appealed to me. Whether one ligates with or without sutures I think depends entirely on the ability to tie around the point of the clamp. If a sharp-pointed clamp is used, ligating is most difficult without suture, and there is certainly no objection to suturing unless it be the additional time consumed. In certain areas of the

tonsil fossae it is almost impossible to ligate without sutures regardless of the type of hemostat used.

The cause of the secondary hemorrhage has been attributed by some to infection, and they think they have reduced the incidence by giving penicillin or Combiotic postoperatively. Several give one dose on the operating table. I cannot see how one dose of Combiotic would influence infection in the tonsil fossae six to eight days later. Most writers believe that secondary hemorrhage is due to a premature separation of the slough which is always present whether or not antibiotics have been given. This explanation certainly serves a good purpose in explaining the phenomenon to the parents. I do not tell my parents that their child bled because I infected his throat.

In studying the literature it is interesting to note the various methods that are used in ascertaining statistics in regard to incidence of primary and secondary hemorrhage. For the most part the incidence of postoperative hemorrhage is given and no mention made as to whether the information was secured from studying hospital charts, office records, questionnaires to parents or what. These reports incidentally include the lowest incidence, as for example, "In 332 cases of the author's experience for which some statistical data were obtained, the incidence of hemorrhage was 0.6%." This is quite a contrast to the statistics of McLaurin and Raggio, who stated, "Hemorrhage occurred primarily 82 times and secondarily 160 times in 2,739 cases." This is an incidence of 242 hemorrhages in 2,739 cases, or approximately 9 per cent. The incidence in the former series would represent six hemorrhages in 1,000 operations, or in the latter series, 17 hemorrhages rather than the 242 reported. On the other hand, I am sure it would be possible to select a small consecutive group from the large series of McLaurin and Raggio and find an incidence of hemorrhage of possibly 1 or 2 per cent, or perhaps even lower, but I question selecting any consecutive series of 300 cases with an incidence of 0.6 per cent.

All are familiar with the papers written on the subject of the influence acetylsalicylic acid has on postoperative hemorrhages in tonsillectomies and adenoidectomies, and I believe most everyone is in agreement now that the amount of aspirin prescribed has no influence on prothrombin time and on these postoperative hemorrhages.



The effect of vitamin K, C.V.P., calcium and vitamin C has been given considerable study, and there are several papers which are convincing if one ignores the chance of statistical inaccuracy which I have mentioned. As I have stated before, I have given calcium to children subjected to tonsillectomy and adenoidectomy. I believe that vitamin K is probably a much more important factor and in the future I plan to give my patients vitamin K preoperatively; however, I chose to finish this study before doing so. In the literature reference is made to the toxic dose of vitamin K. As far as I can ascertain, the toxic dose is 400 mg.; so I think one is always safe in prescribing the 10 mg. which is the usual dose.

In my series of 1,150 consecutive tonsillectomies and adenoidectomies, statistical data were obtained by studying the hospital and office records and questionnaires to the patients. Of 1,040 questionnaires mailed, 968 cards were filled out and returned. The over-all incidence of postoperative hemorrhage which required medical attention was 3.1 per cent. This figure did not take into consideration 24 cases in which packs were placed in the nasopharynx immediately following operation; it did, however, include those cases in which nasopharyngeal packs had to be replaced because of subsequent bleeding. Also not included were 21 cards from mothers with such statements as "the child bled a little on the way home in the car," or "she noted some blood on the pillow one morning."

**Table 2.—Number of Bleeders Ascertained from Returned Cards**

Number of cards mailed	1,040
Number of cards returned	968
Number of bleeders	49 = 5.06
Number of bleeders requiring medical attention	28 = 2.89
Bleeding mentioned	12 = 2.16

**Table 3.—Information Requested on Cards**

Did bleeding occur after leaving hospital?  
If so, when did it occur?  
Was medical attention given?  
If medical attention was given, please describe:

**Table 4.—Data Obtained From Hospital Records and Total Number of Hemorrhages of All Types**

Number of hemorrhages	42
Number of patients given Adrenosem and vitamin K at operation	70
Number of patients requiring nasopharyngeal packs	24
Total number of hemorrhages from cards and hospital records	91 — 7.91%

### Atelectasis and Lung Abscess

Abscess of the lung is of course one of the feared complications of tonsillectomy and adenoidectomy. Today, when one operates with the patient in the Trendelenburg position with the head down, this complication is somewhat rare, but it should still be considered as a possibility. For instance, in England analysis of 11,000 cases in which autopsies were performed showed that abscess of the lung occurred 199 times and in only two cases did the abscess follow tonsillectomy. Reports of American authors vary greatly. Flick studied 172 patients with abscess of the lung with foreign body and neoplasm excluded as a cause. In 121 instances, or 70 per cent, the abscess occurred postoperatively. Of these, the abscess in 97, or 56 per cent of the entire series, followed tonsillectomy. Of this number, the abscess in 88, or 51 per cent of all cases, occurred after the use of general anesthesia. Hedblom reported 692 cases of abscess of the lung. The abscess in 146 cases occurred postoperatively and in 47 cases, or 32 per cent, followed tonsillectomy. The Mayo Clinic reported 16,000 tonsillectomies performed with local anesthesia, and abscess of the lung occurred in two cases. I recall clearly the high incidence of atelectasis and abscess of the lung following tonsillectomies and adenoidectomies when it was customary for two residents to perform the operation with the child in a sitting position. There is here a good argument against performing tonsillectomies in adults under general anesthesia; however, in the literature there are a number of reports of cases of massive atelectasis and abscess of the lung following tonsillectomy under local anesthesia.

I am happy to report that in my small series of cases there was no incidence of atelectasis or abscess of the lung.

### Mortality

One author stated: "The anatomical accessibility and doubtful physiological value of the palatine tonsil are responsible for the fact that tonsillectomy accounted for approximately one third of all operations carried out in the United States since 1924. Although tonsillectomy is a minor operation carried out on fit children, complications are apt to occur. And there can be no greater tragedy than the death of a healthy child as a result of a minor and possibly an unnecessary operation. In Britain, according to the Registrar General's figures, approximately 40



deaths per year are attributable to this operation." Cummings reviewed 20,000 tonsillectomies and adenoidectomies in a town of approximately 100,000 population from the standpoint of mortality and morbidity. In this series there were nine deaths; four from hemorrhage, two at the time of operation and two from postoperative bleeding; three from cardiac arrest; and two from the anesthetic. Incidentally, in this series there were seven instances of abscess of the lung. In the discussion of this paper, one of the discussers stated, "In my experience with tonsillectomies over the years, I have worked on probably more than twice as many cases as reported by the speaker, my own cases, all with open-drop ether and never had any trouble. I have not had a death or any sort of morbidity; maybe some occasional bleeding." I am sure this discussor conscientiously believes that he has performed 40,000 tonsillectomies and adenoidectomies, as most all of us do at times; however, if he were to get pencil and paper out and start figuring, he would discover that this feat is almost an impossibility.

**Table 5.—Summary of Morbidity and Mortality**

Morbidity	
Hemorrhages — hospital records	42 = 3.65 %
Hemorrhages — cards	49 = 4.26 %
Hemorrhages requiring medical attention	28 = 2.43 %
Atelectasis	None
Lung abscess	None
Retained nasopharyngeal pack	1
Mortality	None

### Conclusion

A series of 1,150 consecutive tonsillectomies and adenoidectomies is reviewed from the standpoint of incidence of postoperative bleeding, preoperative medication and anesthesia.

Data for this study were obtained from hospital records, office records and questionnaires.

The over-all incidence of postoperative bleeding in this series was 7.91 per cent. The incidence of postoperative bleeding requiring medical attention was 3.1 per cent.

Reference is made to the possibility of statistical inaccuracies in studies of postoperative bleeding following tonsillectomies and adenoidectomies.

The use of intubation for tonsillectomy and adenoidectomy anesthesia is discussed.

Experience with rectal Pentothal Sodium in 385 cases in this series and in a total of 1,187 collected cases is mentioned.

Comprehensive indications for tonsillectomy and adenoidectomy are listed and discussed.

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# Acute Perforation of Intestinal Reduplication

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Intestinal reduplication is a medical rarity, which by virtue of the recent intensive interest in pediatric anomalies, has received increasing attention. The occurrence of acute perforation in the reduplicated segment of intestine is even more unusual, there being six reported cases in the literature (table 1).<sup>1-6</sup>

The complication of acute perforation in the reduplicated segment of bowel would appear to be primarily a pediatric surgical problem, but the case reported herein would indicate that the geriatric end of the chronologic spectrum also has its surgical surprises. Moore<sup>4</sup> reported an ileal reduplication in a 67 year old man, which produced obstructive symptoms and was resected successfully. There was no sign of perforation in his case.

## Report of Case

A 76 year old Negro man was admitted to the hospital on Feb. 2, 1956, with a complaint of progressive constipation of unknown duration. His senescence made history taking tedious and of questionable accuracy, but apparently the patient had noted increasing constipation with gaseous distention for at least two or three months. On the day of admission he had suffered rather acute lower abdominal pain, nausea, vomiting, and rapid abdominal distention. There had been obstipation of two days' duration prior to admission. There was no history of melena.

The past history revealed exertional dyspnea with "asthma" attacks of 12 years' duration. He had undergone left orchiectomy in 1945 at another hospital for unknown indication. A left-sided hemiparesis had occurred two years previously.

Physical examination disclosed a temperature of 99 F., pulse rate 104, rate of respiration 20, and blood pressure 135/75. The general appearance suggested advanced senility, but the sensorium was reasonably intact. Coarse rhonchi were audible over both lung fields, the chest being of emphysematous contour. The abdomen was diffusely distended with generalized tenderness and tympany. Minimal rebound tenderness was present in both lower quadrants. No abdominal masses could be felt. Bowel sounds were sparse and low-pitched. Rectal examination gave negative results. Admission laboratory findings showed a normal hemogram, a white blood cell count of 8,000, electrolytes normal, and nonprotein nitrogen 88 mg. per hundred cubic centimeters. The urine was normal save for a trace of albumin.

After negative sigmoidoscopy, an emergency barium enema was given, and roentgen examination showed only multiple diverticula; however, there were evidences of air-fluid levels in the small intestine, and the patient was prepared by the usual means for immediate operation. Upon abdominal exploration, a reduplication of the distal ileum was noted, with free perforation of the distal extremity of the reduplicated segment. The reduplicated segment lay in the distal 18 inches of ileum and measured

about 5 inches in length. It was intimately attached to the parent ileum throughout its proximal 3 inches, where although a seromuscular longitudinal ridge was visible, there seemed to be an intimate relationship between the muscular coats of the reduplication and the parent bowel. The vascular arcades extended across both parent and duplicated limbs of intestine. A tiny film of separate mesentery was attached from the tip of the reduplication to the antimesenteric border of the parent ileum, although the reduplication itself actually lay lateral to the parent bowel and not on its antimesenteric border.

The acute perforation of the distal end of the reduplicated segment was apparently the result of back pressure produced by an obstructing, apparently congenital, thick adhesive band which compressed the main channel of the ileum about 4 cm. beyond the site of reduplication. There was moderate soilage of the general peritoneal cavity with turbid intestinal content. The area of reduplication with its adjacent main channel of ileum was resected, and an end to end anastomosis completed. Postoperatively, the patient did well and was discharged ambulatory on February 16. Follow-up for the ensuing three months revealed no problems related to the digestive tract.

Pathologic examination of the excised specimen showed a 20 cm. length of small bowel with attached mesentery. There was a reduplicated segment of intestine approximately 8 cm. in length closely allied to the seromuscular layers of the main channel of ileum (fig. 1). The mucosa of the duplicated segment was continuous with that of the main length of small bowel, though there was a small ridge separating the two. In the distalmost portion of the secondary bowel projection was an area of acute perforation. Microscopic examination showed acute and chronic inflammatory cells over the serosal surface with increased vascularity of the serosa. The epithelium was everywhere that of small bowel, no gastric mucosa or ectopic pancreatic mucosa being noted. In the reduplicated segment, at the site of perforation, several sections showed granulation tissue, edema, and chronic and acute inflammatory cells with fibrin deposition.

## Discussion

Perforation of an ileal reduplication has been reported in six patients ranging in age from five months to 16 years. Of these, four underwent successful resection with recovery. In five of the reported cases there was gastric mucosa within the reduplicated segment; in three cases the perforation had taken place through areas of typical peptic ulceration. The present case in a man of 76 years is, of course, difficult to explain in view of the late obstructive perforation in the presence of what appeared to be a congenital adhesive band. There was no evidence of peptic ulceration at the site of perforation, or of ectopic pancreatic mucosa, the lumen of the reduplicated segment being lined with otherwise normal small intestinal epithelium. The fact that the patient lived for so many decades without prior difficulty is a fasci-

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**Table 1. — Reported Cases of Acute Perforation in Reduplicated Segment of Intestine**

Author	Site	Treatment
1. Edwards <sup>2</sup> 1929	Ileum (Peptic ulceration)	Resection; recovery
2. Black and Benjamin <sup>1</sup> 1936	Ileum (Peptic ulceration)	No surgery; death
3. Gross, Holcomb, Farber <sup>3</sup> 1952	Jejunum and ileum	Resection; death
4. Moore and Battersby <sup>4</sup> 1952	Ileum (Chronic perforation and peptic ulceration)	Resection; recovery
5. Schein and Grundfest <sup>5</sup> 1957	Ileum and thorax (Gastric mucosa with peptic ulceration)	Resection; recovery
6. Stagg and Lynn <sup>6</sup> 1958	Ileum and thorax (Gastric mucosa)	Resection; recovery

nating feature of asymptomatic congenital anomalies, which, for reasons unknown, produce symptoms late in life. This has been observed in a different type of anomalous gastrointestinal lesion, where duodenal obstruction from the congenital bands associated with malrotation of the colon and midgut volvulus did not appear until the age of 63 years.<sup>7</sup>

The embryology of reduplications has been thoroughly discussed in previous papers on this subject by Bremer,<sup>8</sup> Ripstein,<sup>9</sup> Johnson,<sup>10</sup> and Lewis and Thyng.<sup>11</sup> It is not clear as to whether the mechanisms of formation of reduplicated segments of bowel are related to the persistence of embryologic diverticula,<sup>11</sup> or to a coalescence of intraepithelial vacuoles which persisted after the solid phase of bowel formation.<sup>8,10</sup> It is possible that the spherical duplications, frequently classified as mesenteric cysts or enteric cysts, are of different embryologic origin than the more common tubular reduplications. It would seem unlikely that all intestinal reduplications arise from the same types of embryologic misfiring, in view of the wide variation in their location within the gastrointestinal tract, and a similar wide variation in their resultant form. Reduplications of intestinal segments occur most frequently in the ileum,<sup>3,12</sup> but have been reported from the tongue to the rectum, and run the gamut from simple cyst formation, smooth muscle unepithelialized spherical masses, and gastric mucosal line intrathoracic cysts to the present less dramatic variety of tubular reduplication.<sup>3,4,12</sup>

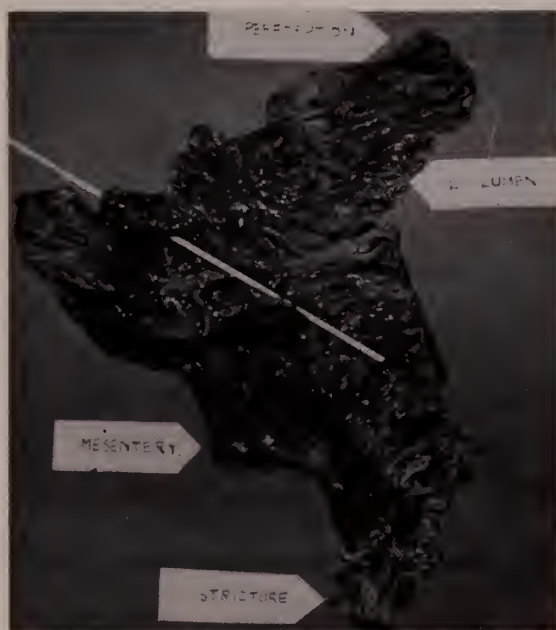
From a surgical pathologic standpoint, it would appear from the small reported experience that gastric heterotopia with ulceration is a frequent cause of perforation, but other cases are essentially unexplained. The present case very likely represents simple perforation in a congenitally defective area, secondary to complete in-

testinal obstruction and the pressure effects thereof. Other symptomatic reduplications have clinically presented as the leading point of an intussusception, with intestinal hemorrhage, or by producing obstructive compression of the mated limb of bowel. Occasionally the reduplications appear as a palpable mass without other symptoms.

Treatment should include resection of the two limbs of bowel, as circulatory and muscular continuity, either partial or complete, is the rule in this abnormality.

### Summary

An unusual case of perforation of an ileal reduplication in late adulthood is reported. Successful resection was carried out.



**Fig. 1. — Gross specimen of intestinal reduplication showing point of perforation in the secondary lumen and area of stricture in the parent lumen, where congenital band had produced obstruction. The probe lies in the main lumen.**



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## Werner's Syndrome

### *Report of Case With Unusual Complication*

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It was in 1904 that Werner<sup>1</sup> described the occurrence of cataracts and scleroderma in four siblings. Oppenheimer and Kugel<sup>2</sup> reported the first two cases in American literature in 1934 and listed the manifestations of what they called Werner's syndrome. Subsequently, Thannhauser<sup>3</sup> reviewed 22 cases plus four of his own in 1945, and Maeder<sup>4</sup> reviewed the literature and collected 47 cases in 1949. More recently, Irwin and Ward<sup>5</sup> set the total number of reported cases at 57. Six more cases have been added,<sup>6-15</sup> bringing the total to 63.

Manifestations of Werner's syndrome include:

- I. Characteristic Habitus and Stature
  - A. Short stature beginning with adolescence
  - B. Slender extremities with a stocky trunk
  - C. Beak-shaped nose
- II. Premature Senility
  - A. Premature gray hair
  - B. Premature baldness
  - C. Atrophic skin
  - D. Weak and high-pitched voice
  - E. Juvenile cataracts
- III. Scleroderma-like Changes
  - A. Atrophic skin and subcutaneous tissue, rather than skin with marked increase in collagenous tissue typical of true scleroderma
  - B. Circumscribed hyperkeratoses
  - C. Skin tight over bones of feet
  - D. Ulcers over malleoli of ankles, Achilles tendon, heels and toes

#### IV. Other Manifestations

- A. Tendency to diabetes mellitus
- B. Hypogonadism
- C. Osteoporosis
- D. Localized calcification
- E. Tendency to occur in siblings

#### Report of Case

A 42 year old white married woman was admitted to the hospital on April 19, 1957, because of progressive abdominal enlargement and an ulcer of the heel. When she was 18 years of age, her hair had begun to turn gray. She married several years later and at the age of 25 bore a son. Within one week after this event, contractures of the toes were noted. The right great toe was pulled upward and outward, and the remainder became hammer toes. Some months later, ulcers developed on the legs and feet. At this time, a cataract was seen in the right eye. Within six months, severe muscle wasting with atrophy of the subcutaneous tissues became apparent. The family noticed that her voice had become thin and scratchy. A diagnosis of scleroderma was made at this time. She was hospitalized several times over the next four years for skin grafts to the leg and heels. It was on one of the hospitalizations that the diagnosis of Werner's syndrome was made. She later came under the care of Dr. B. S. Oppenheimer,<sup>2</sup> who had reported the first case in the American literature.

Six years ago, polydipsia, polyuria, and nocturia developed. On further investigation, a diagnosis of diabetes mellitus was made, and she was given a limited diet with 20 units of NPH insulin daily. On this regimen, however, the patient suffered frequent severe hypoglycemic reactions, and the insulin was discontinued. She was maintained on a diabetic diet for the next 18 months. New ulcers on the heels and Achilles area then developed which became difficult to handle. Insulin was therefore again administered. Her weight at that time was 110 pounds. A bone survey revealed extensive demineralization of all bones. A roentgenogram of the chest and an esophagram were normal.

In October 1955, a cataract was removed from the right eye, and in December of the same year, a cataract was removed from the left eye. She recovered from these procedures with little difficulty. Shortly thereafter, she moved to Florida. Her over-all condition remained essentially unchanged for the next six months. She still re-

quired 20 units of insulin with a dietary intake of 2,500 calories. One month prior to hospitalization, she began to complain of progressive abdominal enlargement, pain in the right upper quadrant of the abdomen, weakness and anorexia. Over the next few weeks, she became almost bedridden.

**Family History.**—The patient was the third of five children. All of the sisters grayed at an early age. None manifested the signs of Werner's syndrome. The mother and father were first cousins. The patient's son, now 16 years old, was well developed and showed no signs of the disease.

**Physical Examination.**—On admission, examination revealed a thin, small white female who appeared chronically ill, but who was alert, cooperative and well oriented. Her weight was 86 pounds, and her height measured 58 inches. The hair was sparse and completely gray. The ears appeared large and protruding; the nose was beak-shaped. Ocular examination revealed a bilateral arcus senilis, irregular pupils reacting poorly to light and accommodation, and small hemorrhages bilaterally in the fundi. The tongue was smooth and the mouth edentulous with plates. The thyroid gland was not enlarged to palpation. The heart sounds were of good quality; the blood pressure was 100 systolic and 52 diastolic; and there was a grade II apical systolic murmur, without radiation. Fine basilar rales were noted over both lungs, without dullness to percussion.

On examination of the abdomen, the liver was palpable five fingerbreadths below the right costal margin and slightly tender to palpation. The edge was firm and irregular. A pelvic examination was unrevealing. All four extremities showed extreme wasting of muscles and subcutaneous tissue. The skin was thin, dry, and inelastic. There was a deep ulcer of the right heel with some purulent drainage. A severe contracture of the right great toe was present with the toe turned so as to overlap the second and third toes. No enlarged lymphatic nodes were found. The neurologic examination gave normal results. The hemoglobin estimation on admission was 9.2 Gm., the red blood cell count 3.5 million and the white blood cell count 10,900, with a normal differential study. The urine showed 4 plus sugar, a trace of albumin, 1 to 2 hyaline casts, and 4 to 7 white blood cells per high power field. A fasting blood sugar determination was 188 mg. per hundred cubic centimeters. Following a transfusion, the hemoglobin level rose to 11 Gm.

The hospital course was progressively downhill. During the first weeks of hospitalization, the diabetes was rather difficult to control. Ten days after the patient was admitted ascites developed, which necessitated several paracenteses. Each time, about 8,000 cc. was removed. This fluid was amber, clear and not bloody. Two Papanicolaou smears were negative. She continued to complain of pain in the right upper quadrant of the abdomen throughout her hospitalization. Liver biopsy was proposed, but because of her poor condition, it was not performed. She died on Oct. 13, 1957.

**Postmortem Examination.**—The body was that of a severely cachectic white woman of 42 years. The body looked much older than the given age. The heart weighed 320 Gm.; there was moderate coronary arteriosclerosis without obstruction of any of the vessels. Microscopic examination showed modest myocardial fibrosis. The liver weighed 3,800 Gm.; it was riddled with tumor tissue; the extrahepatic biliary system was patent. Microscopically, the parenchyma was not remarkable; the striking finding was the presence of an adenocarcinoma which had arisen from the radicals of the hepatic ducts.

The right adrenal gland measured 3 by 2.5 by 1 cc. and weighed 61 Gm.; the left adrenal gland weighed 96 Gm. and measured 4 by 4 by 3 cc. Both showed cortical adenomas and both were invaded by tumor. In the left adrenal gland, the tumor was pleomorphic; some portions of it were so anaplastic as not to resemble the primary adenocarcinoma. The pituitary body was atrophic; the surviving cells were eosinophils. The thyroid gland was atrophic; the acini were lined with flattened cells, and the colloid was scanty. The pancreas showed arteriosclerosis, fine fibrosis, and nonhyalinized islets. There were numerous foci of adenocarcinomatous metastases.

The brain was exceedingly small; it weighed 950 Gm. There was a tumor mass 2.5 cm. in diameter lying in the superior longitudinal fissure and extending laterally into the frontal lobes. Microscopically, this was a meningioma. The spinal cord showed some atrophy of the anterior and lateral cerebrospinal tracts.

The horny layer of the skin was hypertrophied and hyperkeratotic. The dermis showed marked degeneration of the collagen. The dermal appendages were surrounded with hyalinized connective tissue. This did not have the appearance of scleroderma, but appeared to be an involutional atrophy due to arteriolosclerosis.

### Comment

Werner's disease is a recessive hereditary disorder tending to occur collaterally in the same generation. The involvement of the skin and lenses suggests that it is due to a disorder of the genes affecting the ectodermal layer, but organs from other layers may be involved. The pituitary body, being ectodermal in origin, is frequently involved, and there is often pluriglandular involvement.

The patient in the case reported fulfilled many of the criteria necessary for a diagnosis. She was of short stature, with premature gray and sparse hair; she had cataracts, atrophic skin, a weak high-pitched voice, ulcers over the malleoli and Achilles areas, diabetes mellitus, osteoporosis, and hypogonadism.

Many of the patients with this condition die of malignant disease. Of three cases coming to autopsy in Oppenheimer's series, in one the patient died of primary cancer of the liver, and in the second case of fibrosarcoma of the radius. In another series at Montefiore Hospital, of four cases studied, in three the patient died of malignant disease involving different tissues.

The treatment of Werner's syndrome is symptomatic. If diabetes is present, it should be managed in the appropriate manner, although in many of the patients it is difficult to control. Excision of the cataracts which develop is indicated. Therapy of the ulcers when of the skin of the extremities is often most difficult. Thannhauser<sup>3</sup> believed that skin grafting is helpful. In this patient, the grafts once established did not break down. Sympathectomy as reported by Boatwright<sup>11</sup> was not successful. Irwin and Ward<sup>5</sup> tried testosterone in one case over a long period of time, but this therapy resulted in no improvement whatever.

### Summary

A case of Werner's syndrome with the autopsy findings is presented. The cause of death was a primary adenocarcinoma of the hepatic ducts. The clinical features of Werner's syndrome are outlined.



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# The Care of the Dying Patient

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Although the physician is primarily concerned with the assistance he can give to the individual as he enters this world and with the methods available to keep him here as long as possible, he must not forget, since death is inevitable, that it is also his duty to care for the individual as he leaves this world. That this function of the physician is perhaps being neglected is voiced by Worcester<sup>1</sup> in his book, "The Care of the Aged, the Dying, and the Dead," in which he stated, "During the past half century, as we all know, there has been vast improvement in mid-wifery. But instead of any progress in the art of caring for the dying, medical practice seems to have deteriorated."

The care of the dying patient presents a complex situation in which the physician must coordinate the activities of a team which may include other physicians, nurses, clergy, family, friends and social workers in order to give the patient the best possible care psychologically and physically. From the psychologic point of view, he must try to evaluate the patient's attitude toward his dying since, as Sutherland<sup>2</sup> stated in discussing the psychologic impact of cancer, "Few patients wish to know that they are going to die, yet the steady deterioration of their physical status makes it necessary for them to handle the evidence of their own mortality."

Since the stages in the development of man, as recapitulated in the growth of the individual, do not supplant each other but exist side by side, the individual's attitude toward death will be a composite of the influences of magic, faith and science.

In the stage of magic, death is not considered as the termination of life, but as one of the states in which the soul leaves the body. Frazer<sup>3</sup> in "The Golden Bough" related the following: "Thus a man of the Wururgen tribe in Australia lay at his last gasp because his spirit had departed from him. A medicine man went in pursuit and caught the spirit by the middle just as it was about to plunge into the sunset glow, which is the light cast by the souls of the dead as they pass in and out of the underworld, where the sun goes to rest. Having captured the vagrant spirit, the doctor brought it back under his oposum rug, laid himself down on the dying man, and put the soul back into him, so that after a time, he revived."

In the stage of faith, death is considered not as an end of life but as a passage to a more desirable form of existence. Ballou<sup>4</sup> in his anthology, "The World Bible," quoted from the Pahlavi Texts of the Zoroastrian Scriptures: "How are the nature of heaven and the comfort and pleasure which are in heaven? The reply is this, that it is lofty, exalted and supreme, most brilliant, most fragrant, most supplied with beautiful existences, most desirable and most good and the place and abode of the sacred beings. And in it are all comfort, pleasure, joy, happiness and welfare, more and better even than the greatest and supremest welfare and pleasure in the world; and there is no want, pain, distress or discomfort whatever in it."

In the stage of science, when the idea of immortality is no longer a matter of faith but only a matter of philosophic speculation, death becomes a terminal event represented by one of the



Fates, Atropos, who carries the shears that cut the thread of life.

This was the dominant concept of death in western civilization until recently when the ideas of Heidegger, a metaphysician, Ehrenberg, a biologist, and Freud, a psychologist, conceived death not as a sudden accidental event at the end of life but as a force which operates continuously throughout the life of the individual.

In the final revision of his theory on instincts of life, Freud postulated instincts which have as their aim the establishment and preservation of greater unities and death instincts which have as their aim the reduction of living things to the inorganic state from which they originally arose. Biologically, the same concepts were expressed in the theories of anabolism and catabolism.

This changing concept of death may eventually lead to a change in the principle, current in modern life, of keeping the dying patient in ignorance of his state. Eissler<sup>5</sup> expressed this idea in his concept of orthothanasia—dying in a manner adequate to the reality of death. In his book, "The Psychiatrist and the Dying Patient," he stated: "Orthothanasia will try to prevent the individual from entering the event in a state of illusions, whether the latter be the result of historical tradition or individual acquisition. Man has so often bravely faced the truth, and the truth about death might be the most difficult to bear. Yet truth, bitter as it is, may enlarge man's self—as it has so often done in the past—and man having shed one more denial, may enjoy the state of enlarged inner freedom despite the recognition of how merciless that reality is of which he is a part."

#### **Psychologic Aspects**

Psychologically, the physician will give the patient the greatest possible help by reinforcing the patient's attempt to handle the problem of his dying at the level of all three stages in development. Thus, at the stage of magic where the ego boundaries are minimal, the patient becomes one with the physician and with the world. At the stage of faith, the patient regards the physician, as he does the clergy, as a representative of a better world with whose help he will enter when he leaves this one. At the stage of science, the patient regards the physician as a friend with whom he can share this final experience in his life as that particular individual.

An excellent example of the appreciation of the psychologic factors in the art of caring for the dying is given by Cushing<sup>6</sup> in his "Life of Sir Wil-

liam Osler," in which a mother describes Osler's care of her dying child:

"He visited our little Janet twice every day from the middle of October until her death a month later, and these visits she looked forward to with pathetic eagerness and joy . . . Instantly the sick room was turned into a fairyland, and in fairy language he would talk about the flowers, the birds, and the dolls. In the course of this he would manage to find out all he wanted to know about the little patient.

"The most exquisite moment came one cold, raw November morning, when the end was near, and he brought out from his pocket a beautiful red rose, carefully wrapped in paper, and told how he had watched this last rose of summer growing in his garden and how the rose called out to him as he passed by, that she wished to go along with him to see his "little lassie." That evening we all had a fairy tea party, at a tiny table by the bed, Sir William talking to the rose, his little lassie and her mother in a most exquisite way . . . and the little girl understood that neither fairies nor people could always have the color of a red rose in their cheeks, or stay as long as they wanted to in one place, but that they nevertheless would be happy in another home and must not let the people they left behind, particularly their parents, feel badly about it; and the little girl understood and was not unhappy."

#### **Physical Aspects**

The physician must concern himself not only with the psychologic needs but also with the physical needs of the dying patient. The control of pain is an important part of the treatment plan of the patient approaching death. If death is expected in a relatively short time, the judicious use of sedatives and narcotics will usually be all that is necessary. For those patients, however, in whom the terminal phase may be prolonged, the use of various surgical procedures such as decompression of obstructed hollow organs and neurosurgical procedures such as chordotomy should also be considered.<sup>7</sup>

In addition to the control of pain, various measures can be instituted to decrease the discomfort of the patient. If the patient can swallow, small amounts of water or water mixed with wine can be given. If choking occurs even with small amounts of water, a gauze wicking with one end in the patient's mouth and the other in a glass of ice water can be used.

Dryness of the mouth due to lack of saliva can be relieved by applying Vaseline to the tongue and by putting bits of ice enmeshed in gauze strips between the gums and the cheek. Excessive amounts of fluid in the mouth can be relieved by the careful use of suction and if suction is not available, by the use of gauze wicking.

Stertorous breathing can be alleviated by turning the patient on his side. If respiration becomes labored, greater freedom for the chest movements can be obtained by sitting the patient up and letting the shoulders fall backward.

Distention of the bladder which would tend to make the patient restless should not be overlooked. In cases in which incontinence is present, an indwelling catheter should be used.

The room should be well lighted, and since the dying patient usually complains of feeling too hot, enough ventilation should be provided.

The physician having given to the best of his ability all the psychologic and physical help possible in the terminal phase will have performed the final duty as a physician caring for his patient.

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## Who Is Minding the Store?

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"Public affairs are not steadily and quietly conducted when the Government is nothing but a continued scuffle between the magistrate and the multitude; in which sometimes the one and sometimes the other is uppermost; in which they alternately yield and prevail, in a series of contemptible victories and scandalous submissions. The temper of the people among whom we reside ought therefore to be our first study. Knowledge of this temper is by no means impossible for us to attain, if we have not an interest in being ignorant of what it is our duty to learn." Edmund Burke, "Thoughts on Public Discontents."

Last spring our Board of Governors considered how best to regard unreasonable public comments concerning our profession. The year now coming to an end has offered some time for contemplation, and I presume to remind them, and also the rest of us, that those storms of criticism show no sign of making apologetic departure. New examples come regularly. They permit us no longer to slumber, rather hoping that someone, anyone but ourselves, will explain to others those virtues of which we seem so confident.

#### Inverting the Image of Medicine

Last week, at a meeting of some dozens of leading citizens of this community, the chairman asked: "Can anyone here suggest a method of attracting the medical profession, of inducing our doctors to lend their strength to something other than the padding of their own bank accounts?"

A few days later a Tampa lawyer attacked the medical witnesses who had testified against his client. He remarked: "You usually have to send the bailiff to get physicians to testify, but in this case they were out to get my client. . . . Doctors have become the most arrogant people in this country, but to wreck (my client) they were willing to sacrifice thousand dollar bills they make every day."

Now, you may find this comical. You may believe that this single half-truth is not worthy of rebuttal. But the items accumulate, and who speaks for us?

An editorial, locally published, said: "Let's take the price tag off pain."

A Supreme Court Justice said that in his profession, and ours, there are those who "pursue their callings too narrowly, stick too confinedly in a narrow group, and live within their profession too exclusively."

An editorial in a conservative New Hampshire paper asked: "Who is supposed to govern these men, the doctors, who are supposed to donate their life for saving lives? The answer to it is: their consciences, but in these days, in our land, the voice of conscience has grown very dim."

A news story from New York State told of a man, "distracted . . . over mounting medical bills," who killed his wife and attempted suicide.



The Wall Street Journal tells us that more than twelve and one-half million people will be covered by the proposed revision of Social Security involving medical care. Lobbyists for unions are giving top priority to this and other welfare bills. A key House Democrat predicts that if the Congress starts moving in on Social Security any time during the next two years, it will be impossible to keep the Forand Bill out of consideration.

A letter in the New England Journal of Medicine, written by a former British physician, warns us: "Either be prepared to take on leadership, or be prepared to be swallowed up by the inexorable and all-consuming fire of the Welfare State." To this observer we seem to be doing little to defend our ramparts, which are crumbling before our eyes, offering little or nothing in the way of real, vital leadership. We forget that our licenses are granted by secular law, and may be regulated by a modification of that law, whenever the majority of the people decide, or are persuaded to modify it.

A medical director of a major life insurance company tells of his experiences with major hospital insurance:

1. A patient whose annual income was \$2,500 was charged \$2,500 for a lung operation.
2. A patient whose annual income was \$2,500 was charged \$1,500 for a stomach operation.
3. A woman whose husband makes \$6,000 a year was charged \$1,200 for a minor gynecologic operation.
4. A patient whose annual income was \$4,000 was charged \$1,000 for a minor bone operation.
5. A common laborer was sent a surgeon's bill for \$2,500 for amputation and treatment of a fracture.

These data come from Blue Shield:

1. A subscriber who had received routine notification of payment wrote: "I am glad you payed my doctor \$150, but he did not take out my appendix. He removed a small wart from my neck."
2. Another wrote: "People obviously don't know how to keep records. My doctor didn't treat me eleven times last month. He saw me only once."
3. "Careful probing of the thousands of such replies has shown . . . most often . . . atrocious over-charges . . . fictitious services . . . imaginary house calls, office

visits . . . wholesale chiseling by charging for imaginary x-ray and laboratory tests."

A story in The Saturday Evening Post not long ago said that 14 per cent of insured patients, but only 9 per cent of uninsured patients, go to hospitals each year. While in the hospitals, 9 per cent of the insured patients, but only 5 per cent of the uninsured patients, had operations. The rate for appendicitis operations was 11 per thousand for insured patients, but only five per thousand for uninsured patients.

The Michigan State Medical Society surveyed 12,000 consecutive hospital admissions. It found a total of 76,000 hospital days, and of these 11,000 were considered to be unnecessary. Fourteen per cent of the patients paying their own bills were found to have come to the hospital unnecessarily, or to have stayed unnecessarily long. For these same unnecessary or prolonged stays, 30 per cent were attributable to patients with commercial hospital insurance, and 36 per cent to patients with Blue Cross insurance.

A reporter wrote, within the past year: "Most doctors are undercover politicians, jockey for position . . . fear each other . . . general practitioners are egotists who feel they know more about law than the lawyers, more about writing than the authors, and more about emotional problems than a psychiatrist. Doctors are among the most adroit income tax dodgers. Much of their business, in common with headwaiters and cab drivers, is in cash, and I have never met a doctor who overestimated his income."

A reporter wrote: "I am not opposed to the average doctor . . . I am opposed to the doctors who pretend to be on a sacred mission in life while gouging the poor for all the traffic will bear."

An editor comments: ". . . certain physicians habitually over-charge patients with health insurance . . . some doctors perform unnecessary operations."

A novelist, having spent much time in hospitals, said: "Too many Americans are operated on needlessly because of the fees involved. I believe that the patient with \$100,000 has ten times as much chance of being operated on as the patient with \$10,000."

A locally resident retired physician is quoted as saying: "Many of our older citizens haven't enough to live on today. Heaven help them if they become ill and have to pay medical expenses. Something like the Forand Bill is needed."

A local hospital administrator is quoted as saying: "I think its objectives (the Forand Bill)



are fine. I am not so certain about the methods. But someone must do something. Organized medicine doesn't seem to have the answer."

### Professional Reaction

Now these quotations require little comment, but they do lead us to think. If we believe that no one is after us, that everyone is as pleased with us as we are with ourselves, if we allow this pyramiding of innuendo on isolated fragments of truth to go on, we may confidently expect to end where all feeble overconfident gentlemen end: in the ash can.

We have as yet made no decision as to who should speak for us. If we have, they are speaking in a very low voice. One of us will, on occasion, write a letter to the paper. In some such instances that letter will invite a reply from another doctor, who finds some minute difference of opinion in the ideas of the first letter. This is a madness, my friends, when we not only fail to support our own cause, but debate in public with other doctors, who are perhaps no less honorable than ourselves.

One would have supposed that we might, before now, have been disposed to think of our problems. There is little evidence that we care to think. We participated in a medical forum for several years. We gave it up, for reasons not clear. Were we lazy, or jealous, or selfish? Was it because we hated one single citizen more than we love our profession? Did any come forward, from our own membership, to offer alternate sponsorship? When shall we have another such opportunity to present our ideas, not all of them mean, to that public which reads these statements that I have read to you?

We have no speakers' bureau to which local groups could turn for help. It is not necessary that we sponsor free clinics at Williams Park. We do not need to entertain the people, nor do we need to cringe before them. The truth is that we have made no real effort to present our ideas to the public, which is being daily indoctrinated by those who dislike us, hate us, or find us merely stupid, fatuous, and good bait for any demagogue.

It is a fact that there are over 300 doctors in this community. It is a fact that scarcely more than a baker's dozen have been identified with anything which could be regarded as public service. If we are said to be greedy, or rich, never on call, and interested in nothing but getting rich off people who are in fact impoverished by those who plan *our* future, who is to blame? Could it

be that we, indeed, are to blame for not troubling to dispute their unrealistic nonsense?

A doctor was once looked upon as a beloved citizen. If you are under 40 years of age, you will need to accept my word for this, for you have had little evidence of such affection of late. Those older doctors did not know much; they could cure few diseases. Is it not odd, that, knowing so little, curing so few, they earned that affection for us which we squander by sheer neglect? What are we doing of which we can be proud? Are miracles, magic, all that we find necessary? About us are suspicion, accusation, and a beady-eyed populace which finds increasing mirth in comedians' jokes about the riches of the medical profession. What we may see, if only we will take the trouble to look, is the inversion of the image of medicine.

In our time doctors have lost respect and gained dislike. When an editor, a reporter, a politician, a comedian, a neighbor or a bureaucrat—when these gentlemen now mention the doctor or the practice of medicine, they know exactly what they are doing. They are calling up, in the minds of their listener or their viewers, a new image of the doctor. It is not that image which we are pleased to believe is our present image.

News and propaganda must interest us. The world's reporters and press services cannot deliver one millionth of the news of the world. They have newsmen in key places—the city hall and other political headquarters. They watch the police and hospital areas, the ports, the ships at sea, the planes and trains. Most of what happens is never recorded, anywhere. What these men look for is the explosive incident, the overt act, the unusual, savage, careless or reckless. With such an incident they have their start, and the background will include whatever is fashionable in the area involved. It was Aeschylus who said that men kick most those who are enfeebled. The image of medicine having been inverted into comedy or hate or disdain, stories about doctors in the press and jokes about them tend increasingly to be at the expense of our equanimity.

### Role of Public Relations

This fact of the presentation of news is the reason for public relations representatives. These men know that the workaday world of their affection is not remarkable. They study to find things which are both good and praiseworthy, and also remarkable. These are presented for the consideration of the press, and they frequently make good

copy for the newspapers. These public relations men are also quick to offer countermeasures when it seems that an overt incident has put their employers in a bad light. They need skill, understanding, and great delicacy of method. No club and no hatchet will do here. These men are working to preserve an image, or to produce a better one. The great mass of men do not think except in images. When one mentions a name or phrase, that word or words will call up the image which the hearer has come to identify with that language. But images can be changed.

A group of men, a nation, or a profession can sink, in one short generation, from a position of affection and respect, the image of understanding and confidence, into utter rejection. Some of us remember a time when a banker was looked upon as a man of substance. A school teacher was not always the object of a degrading and public pity, being instead respected and admired. An honest mechanic, in the years of our ancient youth, held no shame for himself nor hatred for others. And our forefathers in medicine had created an image of the doctor which was not comical, nor ridiculous, but was regarded with understanding and confidence.

"I quarrel not with far off foes," said Thoreau, "but with those who, near at home, cooperate with and do the bidding of those far away." And those far away number a good many speculative tyrants who plan our lives, and who, without our cooperation, would be harmless. Must we squat, like timid pygmies, while windy frauds trample our manners, our morals, and our sacred responsibilities into common, defecated rationality? He is a poor advocate of anything but surrender who now remains indifferent, silent or acquiescent. Enemies of his father, and also his children, stalk the earth. And if we regard ourselves as being either beyond hope, or above protest, we might remember our parents, who would despise our dainty aloofness. Will our children, in those years

to come, look back on us only with contempt, because we held neutral membership in a generation of plump, complaisant and sleepy cowards? Will they not curse our blindness and our participation, by retreat, in their own serfdom?

#### Time for Action

I suggest this: let us no longer idle here. It is a time for action. I suggest an annual assessment, from each of us, of not less than \$100, better \$200. This fund should be used to protect our profession by public and authentic truth, administered by those who know how and who will present the case for our profession—for this we need the support of every member of this society. It is possible, even now, to discourage our determined assailants, before they poison the minds of those who might be disposed to remain friendly, but only if we appear to be their friends.

Most Americans still believe in us, as individual physicians. Those doctors known to them seem, at present, to escape that suspicion which is freely mentioned concerning the entire medical profession. Today it is doctors as a lump who are under attack. But each of us suffers when our calling is subjected to generalized criticism. Should mass coercion of medical men, now suggested, finally be accomplished, no one of us will be spared.

These specimens of growing discontent with the medical profession can only be ignored if we care not to exert ourselves. As individuals we are weak, made careless because we excuse ourselves from charges leveled at an anonymous and unrealistic concept of medicine. But we are each being soiled, bit by bit, and when the image of our profession has been inverted, it will be too late. Propaganda is most effective when it is not exposed. Doctors, as a profession, are well able to defend themselves. The question is: will we trouble to attend?

615 Eleventh Street, North.



# Trend in Glaucoma Detection in Florida

HARRY E. SIMMONS

TAMPA

The Florida Council for the Blind, with the guidance of its Eye Medical Advisory Committee and 98 members of a Panel of Ophthalmologists, maintains a vital interest in all efforts to detect glaucoma and follow-up care and treatment. The ophthalmologists in Florida have been impressed by the many national efforts to organize and carry out mass screening for glaucoma in the last few years. They have been impressed by the position taken by the National Society for the Prevention of Blindness in sponsoring glaucoma detection and control programs on a mass basis and on a controlled, continuous basis. The American Medical Association and the American Board of Ophthalmology have publicized experiences to date in holding glaucoma detection programs as well as utilizing the services of general practitioners in everyday diagnostic routine as part of the general physical examination.

National interest in activities in the field of glaucoma detection has begun to bear fruit in the State of Florida. Evidence of this was demonstrated last year when the Florida Lions Foundation for the Blind accepted as its first project the establishment of a glaucoma detection program. Dissemination of information by the 276 Lions Clubs throughout the state concerning the insidiousness of glaucoma and the importance for early detection has been most effective. In 1958 the National Society for the Prevention of Blindness established a Florida Committee and supported its venture by underwriting the expense of a secretary on a part time basis. This Florida Committee has successfully established local committees, under guidance of ophthalmologists, in major cities of this state. The Eye Medical Advisory Committee of this State Agency has endorsed these activities and has established a special committee on glaucoma detection on a continuous basis. The Florida State Board of Health, through its many county health units, has demonstrated a responsibility in this health menace and has cooperated fully in the three major phases

of public education, early diagnostic detection and efforts to insure follow-up care and treatment.

Particular note has been made concerning the national emphasis placed upon case finding and upon one day mass screening programs. The State Agency, Florida Council for the Blind, its Eye Medical Advisory Committee and 98 Panel ophthalmologists are aware of the backlog of medically indigent in need of eye care and the fact that 49 counties in this state do not have ophthalmologists or medical centers. For these reasons they advocate that early efforts be directed toward glaucoma control on a small scale basis. Such early detection and treatment programs should indicate the proportion of the population reporting to such detection programs that is not medically indigent and capable of meeting the cost of follow-up eye care. It should also reveal that proportion of the medically indigent who will need to utilize the resources of the community. Such early experiments in glaucoma control will also help in the selection of technics, tools and equipment most applicable to the needs of Florida.

Evidence of a decision to carry on glaucoma control activities is noted in Palm Beach County. Negotiations are in the making between the Palm Beach County Health Department and the local ophthalmologists to set aside space and equipment for a glaucoma detection program as part of a new county health building. This building should be completed sometime in March 1960. On April 17, 1959, the Community Coordinating Council of Hillsborough County held a Health-orama which also included a control glaucoma detection program and exhibit. The result of this study was reported by Mrs. Marge Crawford, Secretary of the Florida Committee of the National Society for the Prevention of Blindness, and Dr. Rodney Steinmetz on May 2, 1959, during the scientific session of your meeting. The ophthalmologists of Tampa are also discussing the possibility of establishing a glaucoma detection program as part of a hospital outpatient program. The University of Miami, in cooperation with the Jackson Memorial Hospital Department of Ophthalmology, is making definite plans for

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Executive Director, Florida Council for the Blind.  
Annual Report of the Florida Council for the Blind to the  
Florida Society of Ophthalmologists and Otolaryngologists,  
Annual Meeting, Bal Harbour, Miami Beach, May 3, 1959.



carrying on research work in glaucoma detection. The ophthalmologists of Orlando have publicized their intentions of considering the establishment of a similar program in that city. Pensacola has just begun to consider the best methods of organizing programs in that area.

In line with the recommendations of our Eye Medical Advisory Committee and Panel of Ophthalmologists, this State Agency wishes to support future efforts to organize glaucoma control programs as follows:

1. Place considerable emphasis upon the word "control" when referring to glaucoma detection. This implies need for careful planning and preparation.
2. Support the plan to begin with control detection programs similar to those in other large cities as part of an out-patient program.
3. Consider mass screening in those cities and localities where medical care facilities and resources exist and are ready to meet follow-up care needs.
4. Encourage publicity void of emotional and dramatic appeal.
5. Make provisions for referring those with indication of eye diseases to their medical doctor and ophthalmologist.
6. Make provisions for follow-up treatment and care for the medically indigent.

The Florida Council for the Blind is extremely pleased with the concerted efforts described herein and, needless to say, grateful, for this Agency is unable to carry on statewide glaucoma detection programs without the support of ophthalmologists and the local community. We wish to pay our respects to the many ophthalmologists who are busily engaged with their regular office practice, yet are determined in their desires to offer their assistance in their community to those in need and in danger of blindness. The Council feels directly responsible to each community in the prevention of eye disease and also feels a responsibility to protect the interest of each ophthalmologist and his private practice. Knowing that it is an accepted fact that more than 2 per cent of the population have undiagnosed glaucoma, the Council is then obligated to support organized glaucoma detection programs on a planned basis. Beyond public education then, the Council must guide future glaucoma screening and follow-up care activities so that all capable of meeting the cost of medical care be directed to ophthalmologists on a private patient basis and those who cannot pay be attended through the support of local community resources. The Florida Committee of the National Society for the Prevention of Blindness and the Florida Lions Foundation for the Blind are to be commended for their interest in public eye health and their concentrated efforts and determination to support prevention of disease programs locally.

P.O. Box 1229.

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You would like to present at the Florida Medical Association's Eighty-Sixth Annual Meeting, April 8-11, 1960, Jacksonville?

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## ABSTRACTS

**Intravenous Procaine in the Management of Some Cutaneous Manifestations of Collagen Diseases.** By Joseph Farrington, M.D. South. M. J. 51:1426-1431 (Nov.) 1958.

Noting a dearth of literature on the use of procaine intravenously in the treatment of collagen diseases, the author reports studies begun seven years ago which have shown a pattern of response to this drug in some of the cutaneous manifestations of these diseases heretofore unreported. He describes the effects of intravenous procaine in the amelioration of symptoms and cutaneous changes in scleroderma and dermatomyositis. After discussing the pharmacologic aspects, he outlines the treatment and summarizes the results in 71 cases of all types of scleroderma and four cases of dermatomyositis. With few exceptions improvement was variable in degree but permanent. He concludes that intravenous procaine tends to delay progression and to produce a reversion toward normal of certain cutaneous manifestations of some collagen diseases.

**The Problem of Food Allergy.** By Woods A. Howard, M.D. South. M. J. 52:747-749 (June) 1959.

Although dietary means offer the best approach to the problem of food allergy, even then the diagnostic procedure is not simple and requires time and careful analysis. This article points out that despite its high incidence and protean nature, food allergy remains an enigma. Its importance in allergic states, however, must always be considered. There is no simple accurate method of determining the role of foods in a patient exhibiting hypersensitivity reactions. The skin reactions to foods are notoriously inaccurate clinically, but the tests are worth while in most cases of suspected food allergy to determine the patient's constitutional atopic make-up and as an aid in determining the dietary approach to be instituted. The final proof of allergy to foods is the repeated precipitation and relief of symptoms by controlled addition and withdrawal of individual foods to and from the diet.

The author suggests the use of the "rare food diet" as a somewhat different approach to the problem of dietary manipulation. This diet eliminates foods which the patient eats daily and

substitutes equally nutritious foods which are seldom eaten. The use of this list has proved particularly meritorious as a simple screening method in patients with allergic symptoms when food cannot be excluded as the precipitating or aggravating agent by the usual methods employed.

**The Mechanism of Hypoproteinemia Associated With Giant Hypertrophy of the Gastric Mucosa.** By Yale Citrin, M.D., Kenneth Sterling, M.D., and James A. Halsted, M.D. New England J. Med. 257:906-912 (Nov. 7) 1957.

Giant hypertrophy of the gastric mucosa has been known under many synonyms and is a relatively uncommon lesion of the stomach. Hypoproteinemia has been described in some cases of this disease. In this report, the mechanism of hypoproteinemia in a patient was investigated with  $I^{131}$ -labeled albumin. This patient was subsequently examined at autopsy. With the use of  $I^{131}$ -labeled albumin as a tracer it was found that the patient had a small albumin pool turning over rapidly. Significant protein-bound radioactivity was found in the gastric juice. Loss of albumin into the gastric juice and subsequent digestion was believed to be the basic cause of the hypoproteinemia. It is suggested that synthesis of albumin earlier in the illness had failed to compensate for gastrointestinal losses.

**A New Therapeutic Concept of the Exstrophied Bladder.** By Clifford C. Snyder, M.D. Plast. & Reconstruct. Surg. 22:1-10 (July) 1958.

Among the anomalies of the newborn which challenge and intrigue the plastic surgeon, few if any present a more perplexing problem than exstrophy of the urinary bladder. The author discusses the anatomy of this congenital deformity and then, on the basis of his review of some 55 different operations devised to correct this anomaly, summarizes the numerous surgical technics. He observes that according to the literature there were more patients living who were not subjected to operation than were alive after undergoing some type of operative procedure, and he further notes that the operation responsible for the most deaths, that is, some form of ureteroenteric

anastomosis, is the procedure of choice among surgeons today.

Convinced that the plan of a urinary receptacle with intact sphincter function and intestinal continuity should achieve the necessary result to assure normal life expectancy without intercurrent urinary complications, he describes the operative technic he devised and used with success in two cases to achieve this end. While the immediate results of this operation have been good in the two cases reported, and in six others later, he points out that time is necessary to prove that the children will lead a normal life free of recurrent infection. The urinary stream being completely separate from the fecal discharge is of definite advantage as it eliminates ascending renal infection, which is the commonest complication of past operative procedures. There is no problem of ureteral obstruction at a site of anastomosis because the ureters are left intact to empty their contents as they should into the bladder. Also, there is no need for embarrassment due to soiled clothes or uriniferous odors as the anal sphincters are present to serve the patient socially. In the near future he plans to rotate a small adjacent skin flap to separate the urinary rectal receptacle from the anal orifice, and before the children go to school he will correct the epispadiac anomalies.

**Sites of Absorption of Vitamin B<sub>12</sub>.** By Yale Citrin, M.D., Carlo DeRosa, A.B., and James A. Halsted, M.D. *J. Lab. & Clin. Med.* 50:667-672 (Nov.) 1957.

Although a very small proportion of extremely large doses (500 to 2,000 micrograms) of vitamin B<sub>12</sub> can be absorbed, presumably by diffusion, from most mucosal surfaces, the sites of absorption of the much smaller amounts normally available in the diet have not been defined. In this study, the capability of various segments of the intestine to absorb vitamin B<sub>12</sub> was assessed by means of the urinary excretion test after Co<sup>60</sup>-B<sub>12</sub> was delivered through an intestinal tube. Conclusions were: In doses of 0.5 micrograms vitamin B<sub>12</sub> can be absorbed from the entire small intestine provided intrinsic factor is available. Absorption of vitamin B<sub>12</sub> in doses of 0.5 to 3.0 micrograms from the colon could not be demonstrated in 18 tests despite the addition of intrinsic factor to six test doses, and the prior administration of neomycin or tetracycline in six tests with or without intrinsic factor.

As measured by a two day urinary excretion test, the degree of absorption of 0.5 micrograms of vitamin B<sub>12</sub> given orally at seven day intervals was fairly constant in a given subject. Absorption after instillation into the duodenum was significantly greater than after oral administration in six of seven normal subjects. This finding suggests an inhibitory role of the stomach. Possible explanations for this effect are offered.

**Methemoglobinemia Associated With Intestinal Strangulation Obstruction in the Newborn Infant.** By Warren W. Quillian, M.D., James W. Lancaster, M.D., and H. Clinton Davis, M.D., *J. Pediatrics* 53:737-740 (Dec.) 1958.

The possibility of concomitant methemoglobinemia and intestinal obstruction has not been widely discussed. The case reported here is presented as one of an apparent methemoglobinemia which followed an operation for strangulated inguinal hernia in a four week old infant. The various factors which may bear a relationship to the altered blood pigment in this infant are discussed.

**Systemic Reaction After Intravenous Fibrinolysin Therapy.** By Paul W. Boyles, M.D. *J. A. M. A.* 170:1045-1047 (June 27) 1959.

A case is reported in which a 39 year old man, who had had a number of abdominal operations including cholecystectomy and subtotal gastrectomy, suffered an acute ileofemoral vein thrombosis. He experienced a severe systemic reaction after the first intravenous injection of purified human fibrinolysin; he received 100 mg. of heparin and 200,000 units of fibrinolysin. Fever and shock appeared within three hours after the injection, but all tenderness disappeared from the patient's ileofemoral region in approximately 10 hours. Recovery from the thrombosis and from the side effects of the treatment was complete within three days. Immunologic studies suggested that both streptokinase and fibrinolysin antibodies were responsible for the reaction observed. It is suggested that fibrinolysin be used with caution until its mode of action is better understood.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in *The Journal*. If you have no extra reprints, please lend us your copy of the journal containing the article.



## H. R. 4700

I direct these words to my fellow Americans everywhere, to those who believe in the Free Enterprise System of Democratic America. I appeal not only to those who are fellow members of the Medical Profession but to all who rely on and benefit from their advice, counsel and treatment.

The letters and numbers of the title of this message are probably familiar to you by now, but if not, they specify a Bill being presented to the 86th Congress of the United States. This is better known as the Forand Bill authored by Aime J. Forand, a Rhode Island Democratic member of the U. S. House of Representatives. This bill would again increase Social Security taxes and extend hospitalization, nursing home care and surgical services to recipients of Social Security Benefits. At present, this Bill has been "shelved" by the House Ways and Means Committee, stimulated in part by our own H. Phillip Hampton, M.D., Chairman of our Committee on Legislation and Public Policy. Mr. Forand has expressed his hopes of action on this Bill early next year. There is no question but that those who wish to socialize this country will make a big push to pass this legislation when the Congress reconvenes in January 1960.

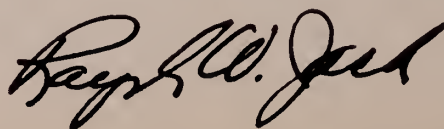
I regret that space here is too limited to give you a complete briefing on this Bill. To present fully all of the evidence against the need or even the advisability of such legislation would require more pages than this entire Journal contains. This Bill can best be summarized as a "new approach to socialized medicine." I have requested the Editors to publish Dr. Hampton's prepared testimony in this issue of The Journal. Several of us representing your interests will be on our way to St. Louis to an American Medical Association conference on this subject the very day this issue comes out. You will have a report of this conference soon.

Since the beginning of this century, revolutionary advances in medicine and better medical care have increased the life expectancy of the average American by 20.5 years. This proposed legislation would result not in better but in poorer health care for the people of this country.

Mr. Forand and proponents of this type of legislation have apparently become confused regarding the true problems facing those who have passed their sixty-fifth birthday in this country. More people live to reach that birthday because of ever improving medical care. They are not in poor health but in better health medically and mentally than ever before. Because of arbitrary age restrictions placed upon them by industry and government, however, they do have a problem—not their health, as suggested by Mr. Forand, but rather their economics. They are arbitrarily pushed out of their jobs and forced onto the unemployed lists. This adds to Medicine's problem of keeping them in good mental and physical health, but our profession is determined that it will do just that. The question is whether the "Do Gooders" such as Mr. Forand and his followers are equally as determined to help these senior citizens in an economic way. A Bill to reduce all taxes of every such citizen by even 50 per cent when he reaches 65 years of age would enable him not only to finance needed hospital and medical care but many other necessities of decent living as well without the necessity of the Federal Government signing a blank check to provide such services.

Detailed information regarding this Bill is impossible for me to give you here. Such has been prepared by, and can be obtained from, The American Medical Association and the Association of American Physicians and Surgeons. Everyone of you should read this material and have it available for your patients. Urge them to express their opinions to their Congressmen. Write your own Congressman and request a copy of H.R. 4700 and after studying its provisions write him again and tell him what you believe regarding it. Assume your rightful role as an intelligent, informed and thinking American citizen—or are you one who is willing soon to have others do your thinking for you?

Remember—the health problems of any age group are the responsibility of the medical profession.



# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## Three Wise Men

Socrates—Baltasar Gracian—and Sir Thomas Browne—three wise men whose personalities and individualities have come to us today down the long stairway of time—they continue to influence our lives and our thinking.

A Philosopher—a Jesuit priest—and a Physician—the last separated from the first by more than two milleniums—they share a common fraternity of discerning clear-sightedness, objectivity and inquisitiveness, with a facility for lucid expression—and a sincere search for truth and tolerance. By any standards, truly they were wise men, as well as gifted ones. Their bold originality—their faculty of remaining unimpressed by conventionality and precedent—their great moral and intellectual courage—should direct and inspire us today toward a more intelligent and unrestricted understanding of, and approach to, the many problems which we stolidly continue to regard in a traditional and stereotyped manner.

Each of these men is a model of clear, concise, disciplined thought—and each was, in his fashion, a paradoxical individual. How paradoxical? Let Sir Thomas Browne explain the paradox of Socrates: "There are many. . . . have their

names in Histories and Martyrologies, who in the eyes of God, are not so perfect martyrs as was that wise heathen Socrates, that suffered on a fundamentall point of religion, the unity of God."

As to Baltasar Gracian, here was a Spanish member of the Society of Jesus—born about 1600 A.D.—with a prolific rapier-like pen—a thinker—a wit—a discerning observer of humankind, whose writing, and whose career, was ultimately curtailed by his Church—a disturbing individual in whose "The Art of Worldly Wisdom" appear the following often unpriestly observations: "Create dependence. The idol is not created by the gilder, but by the genuflector; he who knows, desires more that men shall need him than thank him." "Fortune and fame: the one is as fleeting as the other is lasting. The first for this life, the second for the next: the one against envy, the other against oblivion." "The bastions of men of the world are a gentlemanly and distinguished learning." "Rate the intensive above the extensive." "Let your own integrity be the standard of rectitude, and let your own dictates be stricter than the precepts of any law;" and finally, "Half the world laughs at the other half, even though the lot are fools."

Last of all, the paradox of Sir Thomas Browne—a doctor writing about the religion of a Physician, which he felt obliged to open by acknowledging the “general scandal” of his profession. Sir Thomas Browne, perhaps more than either of the others a very real, knowledgeable and understandable personality, who inspires in us a tremendous respect, not only for his knowledge, but for his inquiring mind, his enthusiastic appetite for knowledge; his fairness and his tolerance—a man who, being deeply religious himself, felt that “persecution is a bad and indirect way to plant religion”—and who recognized that “obstinacy in a bad cause, is but constancy in a good.” A great man and an intimate friend, who seems somehow very close and real to us across the short gap of three centuries. A man, the strength of whose personality is probably best portrayed by J. B. Priestley’s fanciful scene conjured up by a tablet on the site of Dr. Browne’s former house in Norwich, at No. 12 Orford Place:

A story was told that, through a misreading of the tablet, the directory of Norwich for 1929 listed “Browne, Thomas, M. D.,” as a living practitioner; thence Mr. Priestley:

“Don’t you see it? The year is 1929, after the publication of that directory. Late at night, with everything closed solid, a woman is suddenly taken ill and her husband, frantic, grabs for the directory to look for a physician. There is no telephone, but the nearest doctor is a man named Browne, a few squares away. The husband snatches his hat, rushes out into the darkened streets, and in a few minutes is standing before the tablet in Orford Place. Yes, there he is!—‘Thomas Browne, M. D.’—He plunges his thumb into the bell and—”

“And what?” questioned his companion.  
“Gets him,” said Priestley softly.

Truly the shades of these three great men walk beside us throughout our daily lives. Let us turn a more attentive ear to the wisdom and guidance they can give us in molding our moral and intellectual approach to the world about us—and to the religion and philosophy of Medicine.

J. W. A.

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## The Cobalt Bomb

The advent of the Cobalt Bomb has not changed the basic principles of good radiotherapy. Cancer which is incurable by virtue of its histology or anatomic extent will probably still remain incurable. A tumor cell cannot distinguish the *source* of the radiation which may cause its destruction. Thus from the tumor’s point of view, radiation may be delivered by a Cobalt Bomb, x-ray, radium or other isotope; this does not matter to the tumor. It may, however, make some difference to the patient.

The Cobalt Bomb emits million volt gamma rays (x-rays) which are more penetrating, allowing more adequate tumor depth doses, lessened skin and bone reaction, and less “radiation sickness.” Thus a more adequate tumor dose may be delivered with greater comfort to the patient.

This is no small matter, and in some patients may be of critical importance.

We should accept the Cobalt Bomb for what it is—an excellent additional weapon in the armamentarium of the radiotherapist. It is not a miraculous new “discovery” which will cure the incurable. Publicity in this vein in the lay press has been more harmful than helpful. Let us not forget that it is not so much the instrument as it is the one who uses it. Whether it is a scalpel, a drug, or a type of radiation, success or failure still depends in a large measure on the abilities of the physician who uses it.

JOHN D. REEVES, M.D.  
PROFESSOR AND CHAIRMAN,  
DEPARTMENT OF RADIOLOGY,  
COLLEGE OF MEDICINE,  
UNIVERSITY OF FLORIDA



**Florida Academy of General Practice  
Miami Beach, October 29-31, 1959**

The Tenth Annual Scientific Assembly of the Florida Academy of General Practice will be held at the Hotel Seville in Miami Beach on Thursday, Friday and Saturday, October 29-31. Dr. Walter J. Glenn of Fort Lauderdale, President of the Academy, urges all Florida physicians to attend. There is no registration fee. An outstanding characteristic of the meeting will be its informality. Fun will be emphasized, and professional entertainment and dancing will feature the Annual Banquet on Saturday night with addresses banned. The lucky physician whose name is

drawn from the hat at the banquet will receive as a first prize a fiberglass boat, motor and trailer; he need only to have visited the majority of the technical exhibits. Other prizes will include television sets, cameras and other items of real value.

The scientific program will be presented at morning and afternoon sessions on Friday and Saturday. It will cover a wide variety of subjects of broad appeal. Dr. Leonard L. Weil of Miami Beach is chairman of the program committee. The preliminary program follows:

**FLORIDA ACADEMY OF GENERAL PRACTICE  
TENTH ANNUAL SCIENTIFIC ASSEMBLY  
HOTEL SEVILLE, MIAMI BEACH**

**THURSDAY, OCTOBER 29**

1:00 p.m. Registration of Members, Wives, Guests and Exhibitors.

6:00 p.m. President's Special Party for the Exhibitors.

8:00 p.m. Meeting of the Board of Directors and Chairmen of Standing Committees. All FAGP Members welcome.

**FRIDAY, OCTOBER 30**

8:00 a.m. Registration of Members, Wives and Guests

8:30 a.m. Visit the Exhibits.

9:30 a.m. Invocation and Welcome to the Assembly.

Raymond E. Parks, M.D.—“Practical Application With Isotopes.”

James Nugent, M.D.—“Prostatic Cancer.”

Question and Discussion Period

Lunch

1:00 p.m. “The Doctor Defendant,” a film presentation of professional liability actions stemming from breaches of physicians' responsibility.

1:30 p.m. Joseph H. Davis, M.D.—“When to Be Suspicious.”

Phyllis Vaughn, M.D.—“Gout, the Unsuspected Crippler.”

William B. Dyckman, M.D.—“Poisoning, Its Recognition and Treatment.”

Question and Discussion Period

4:30 p.m. Visit the Exhibits.

5:30 p.m. Exhibit Hall closes.

8:00 p.m. General Business Session of the Academy, Dr. Walter J. Glenn, presiding.

**SATURDAY, OCTOBER 31**

8:00 a.m. Registration of Members, Wives and Guests.

8:30 a.m. Visit the Exhibits.

9:00 a.m. “Problems of the Mind in Later Life,” a filmed Symposium on Constructive Medicine in Aging.

9:40 a.m. Jacob Glassman, M.D.—“Surgery That Should Not Have Been Done.”

Ray Simmons, M.D.—“Once a Month—Menses and Their Complications.”

Question and Discussion Period

Lunch

12:30 p.m. Visit the Exhibits.

1:00 p.m. “No Margin for Error,” a film presenting human mistakes in the modern hospital.

1:30 p.m. David Nathan, M.D.—“Arrhythmias—Their Recognition and Treatment.”

Allan A. Kaplan, M.D.—“Twenty-Eight Feet of Trouble—Problems of the Gastrointestinal Tract.”

Question and Discussion Period

5:30 p.m. Exhibit Hall closes.

7:00 p.m. Cocktail Party.

8:00 p.m. Annual Banquet. Entertainment and Dancing. No addresses.

**SUNDAY, NOVEMBER 1**

Noon Poolside Brunch.

**Florida Diabetes Association  
Annual Meeting  
Miami Beach, October 29-30**

The Seventh Annual Meeting of the Florida Diabetes Association will be held in Miami Beach on October 29 and 30, 1959. The Balmoral Hotel will be headquarters, as last year, and registration is scheduled for 9 a.m. on Thursday, October 29. The first of four scientific sessions will begin at 10 a.m. that morning, and the last one will be concluded on Friday afternoon. A public meeting on Friday night will be the closing event. There will be a luncheon meeting of the Board of Governors at noon on Thursday, and the annual business meeting with election of officers will take place at 1:30 p.m. on Friday.

The scientific program is presented in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association. Moderators for the four scientific sessions are Dr. Joseph J. Lowenthal and Dr. L. L. Parks of Jacksonville, Dr. A. Gorman Hills of Miami and Dr. Grover C. Collins of Palatka. The program is approved

for postgraduate study, Category I, by the American Academy of General Practice.

The guest lecturers will be Dr. Nicholas P. Christy, Associate in Medicine, Columbia University College of Physicians and Surgeons, New York, Dr. Jerome W. Conn, Professor of Medicine and Director of Metabolism Research Laboratory, University of Michigan Medical School, Ann Arbor, Mich., and Dr. Francis D. W. Lukens, Professor of Medicine and Director of George S. Cox Medical Research Institute, University of Pennsylvania School of Medicine, Philadelphia. Member speakers will be Dr. Andrew E. Lorincz, Assistant Professor of Pediatrics, College of Medicine, University of Florida, Gainesville, Dr. Bernard H. Marks, Research Instructor, University of Miami School of Medicine, Miami, and Dr. George F. Schmitt Jr., Miami.

The officers of the association are Dr. Lowenthal, President, Jacksonville, Dr. Grover C. Collins, President-Elect, Palatka, and Dr. Morris B. Seltzer, Secretary-Treasurer, Daytona Beach.

**PROGRAM  
SEVENTH ANNUAL MEETING  
FLORIDA DIABETES ASSOCIATION  
BALMORAL HOTEL, MIAMI BEACH, OCTOBER 29-30**

**THURSDAY, OCTOBER 29:**

**MODERATOR: Dr. Joseph J. Lowenthal, President**

9:00	Registration	
10:00	"What Constitutes Diabetes and the Prediabetic State in Man"	Dr. Conn
10:45	Questions	
11:00	Recess	
11:15	"Insulin and Protein Metabolism"	Dr. Lukens
12:00	Questions	
12:30	LUNCHEON MEETING—Board of Governors	

**MODERATOR—Dr. Lorenzo L. Parks**

2:00	"Studies of the Etiology of Cushing's Syndrome"	Dr. Christy
3:00	"Hormonal Control of Fatty Acid Metabolism"	Dr. Marks
3:30	Recess	
3:45	"Connective Tissue Acid Mucopolysaccharides and Their Possible Significance in Endocrine Disorders"	Dr. Lorincz
4:15	Questions	
6:30-7:30	Cocktail Party	

FRIDAY, OCTOBER 30:

MODERATOR: Dr. A. Gorman Hills

10:00	"Assessment of Activity of Sulfonylureas, Clinical and Experimental"	Dr. Lukens
10:45	Questions	
11:00	Recess	
11:15	"Patho-physiology of Hypopituitarism"	Dr. Christy
12:00	Questions	
1:30	BUSINESS MEETING OF ASSOCIATION	

MODERATOR: Dr. Grover C. Collins, Incoming President

2:00	"Kimmelstiel-Wilson Disease"	Dr. Schmitt
2:30	"Primary Aldosteronism, Clinical Considerations and Results to Date"	Dr. Conn
3:15	Recess	
3:30	"A Philosophy of Diabetes"	Dr. Lukens
4:00	Questions	
8:00	PUBLIC MEETING	

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**Southern Medical Association  
Meets in Atlanta  
November 16-19, 1959**

Pointing in the direction of tomorrow will be the theme for the Fifty-Third Annual Meeting of the Southern Medical Association, to be held in Atlanta, Ga., next month. The dates are November 16 through 19, and many Florida physicians among some 13,000 members of that organization are planning to be in attendance. To aid them in meeting tomorrow's demand for improved medical and surgical care, the thousands of physicians from throughout the South who will attend will find this meeting replete with lectures, symposiums, panel discussions and exhibits all designed to help the physician practice better medicine.

Among the newest of the new will be a half day Symposium on Nuclear Medicine, which is scheduled for a general session on Thursday morning, November 19. It is especially planned to acquaint the physician with the practical applications of atomic energy in medicine, proceeding from the elementary aspects of nuclear and space medicine through the more complex techniques, and relating them to the everyday practice of medicine. Also in the direction of tomorrow, this year's Symposium on Geriatrics, likewise scheduled for Thursday morning, will feature dynamic discussions looking to better health care of the aging population. It will be slanted somewhat toward the sociologic features of aging, such as

income, retirement, occupations, entertainment, travel and education, but medical areas will not be neglected.

Programs of the 20 sections will embrace every aspect of medical and surgical practice. Addresses by many distinguished guest speakers highlight these programs. Scientific and technical exhibits, color television programs, section luncheons and dinners, alumni and fraternity reunions and the annual golf tournament are other features of wide appeal. The President's luncheon and President's night are always outstanding events.

Societies meeting conjointly with the Southern Medical Association include the American College of Chest Physicians, Southern Chapter, the American College of Pathology, the Southern Electroencephalographic Society, the Flying Physicians, and the Southern Gynecological and Obstetrical Society.

Two more years will elapse before the Southern Medical Association returns to Florida for an annual meeting. St. Louis will be the host city in 1960, and a Dallas-Fort Worth meeting is scheduled for 1961. In November 1962 Miami Beach will welcome this great gathering of Southern physicians.



### **Obstetricians and Gynecologists Meet in Miami Beach October 29-31, 1959**

The annual meeting of The American College of Obstetricians and Gynecologists, District IV, will be held late this month at the Hotel Americana in Bal Harbour, Miami Beach. Registration will begin at 5 p.m. on Thursday, October 29, and the registration fee is \$10. All registrants and their wives are invited to the cocktail party that evening from 6:30 to 7:30, and to the banquet on Friday night at 8 p.m.

The scientific program will be presented in morning and afternoon sessions on Friday, October 30, and a concluding morning session on Saturday, October 31. The first session, opening at 9 a.m. on Friday will be called to order by Dr. Norman Thornton of Charlottesville, Va., Chairman of District IV, and after Dr. Homer L. Pearson of Miami offers the invocation, the members will be welcomed by Dr. Ralph W. Jack of Miami, President of the Florida Medical Association and Vice President of The American College of Obstetricians and Gynecologists. Dr. Charles J. Collins of Orlando and Dr. Daniel O. Hammond of Miami will preside over this session. An audiovisual program, of which Dr. Lawrence L. Hester Jr. of Charleston, S. C., is chairman, will be presented Friday afternoon. Dr. Richard F. Stover of Miami and Dr. William C. Roberts of Panama City will preside over the session on Saturday morning. Dr. James Henry Ferguson, Professor and Chairman, Department of Obstetrics and Gynecology, University of Miami School of Medicine, is chairman of the scientific program committee.

Among the distinguished guests expected for the meeting are Dr. John I. Brewer of Chicago, President, and Dr. C. Paul Hodgkinson of Detroit, Secretary of The American College of Obstetricians and Gynecologists.

Florida physicians contributing to the scientific program and their subjects are: Drs. William B. Cheslock and John Kruggel, of Orlando, "A Case Report of Clostridia Welchii Complicating Pregnancy and Delivery;" Dr. J. Lee Dockery, of Miami, "Cervical Lesion—Biopsy or Smear?"; Dr. Robert L. Hatton, of Miami, "Coagulation Defects in Patients with Abruptio;" Dr. J. W. Hendrick, of Arlington, "Corticoid Therapy of Infertility Associated With Anovulation and Elevated 17-Ketosteroids;"

Dr. Harry Prystowsky and associates, of Gainesville, "Some Aspects of Oxygen Transfer Across the Placenta at High Altitude (16,000 Feet);" Dr. Harold Schulman, of North Miami, "A Comparison of the Accuracy of Punch and Cone Biopsies;" Dr. Max Suter, of Jacksonville, "Sterilization by Cornual Cauterization;" Drs. J. Champneys Taylor, E. Frank McCall, Sam W. Denham and John B. McCall Jr., of Jacksonville, "Fallopian Tube Salvage at Time of Tubal Pregnancy; Case Report;" and Dr. Paul Taylor Jr., of Opa Locka, "Fungistatic Activity of Human Serum."

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### **Doctors' Deductions for Entertainment Internal Revenue Service Ruling**

For the first time the Internal Revenue Service has specified conditions under which physicians generally may claim costs of entertaining other physicians and in certain instances the laity. Such outlays are now allowable for federal income tax purposes when practitioners can show specific business gains. The ruling states that "the clear relationship of the expenditure to reasonably expected income must be shown." Deductions will not be allowed for repeated entertainment of an individual doctor since that "indicates a personal motive." Even though there is some possibility of a business benefit, the expenditure may not be deducted if personal reasons predominate.

Industrial doctors have somewhat greater latitude. So long as they can prove tangible benefits, they are privileged to claim deductions for entertaining lay persons as well as physicians.

As set forth in The AMA News of Aug. 24, 1959, the general standards prescribed by the Service for establishing the deductibility of entertainment expenses are: "Specific purpose of entertainment; percentage of the doctor's patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from the doctors entertained; whether or not other doctors in the same type practice in the locality have entertainment expenses."

**Florida Medical Association  
Eighty-Sixth Annual Meeting  
April 8-11, 1960, Jacksonville**

### **Testimony on Forand Bill—H.R. 4700**

Congressional hearings on H.R. 4700—Forand Bill—were conducted by the House Ways and Means Committee during the week of July 13 through July 17, at which time the Florida Medical Association was requested to present testimony in opposition to this particular bill. The following presents the testimony as given by H. Phillip Hampton, M.D., who is the American Medical Association Key Contact Physician for Florida.

#### **STATEMENT OF THE FLORIDA MEDICAL ASSOCIATION**

Re: H.R. 4700, 86th Congress  
Amendments to the Social Security Act  
House Ways and Means Committee  
July 14, 1959

Mr. Chairman and Members of the Committee:

I am Dr. H. Phillip Hampton of Tampa, Florida, where I am engaged in the private practice of medicine. I am a Member of the Board of Governors and Chairman of the Legislative and Public Policy Committee of the Florida Medical Association.

If a problem in the economy and distribution of medical and hospital care exists in this country, can it not be solved by application of American ingenuity with the incentive and under the proven principles which have been our strength and not resort to questionably effective plans as tried by other governments foreign to our way and destructive of our traditional principles?\*

That was the purpose of the medical doctors of Florida when, in 1954, they requested the Governor to appoint a committee to study the problems of medical and hospital care in this state with particular reference to those who were unable to provide this care for themselves.

The committee report, published in two volumes, presented the following major findings: Although the Florida constitution charged the county government with the responsibility of providing hospital care for the indigent, the majority of counties either ignored the responsibility or budgeted an amount entirely inadequate to provide proper hospital care. As a result (a) hospitals were usually required to absorb all or part of the cost of indigent hospitalization and passed this cost on to paying hospital patients and (b) the county lines often acted as a barrier to good medical care and prevented efficient use of existing hospitals established under the regional hospital system in neighboring counties.

There are two groups of individuals unable to pay for medical and hospital care: (a) those persons on the state welfare rolls who require public assistance for food, clothing, and shelter and (b) those persons who, after proper investigation, are found able to provide the basic necessities for themselves but cannot meet the cost of medical care and hospitalization—the medically indigent.

The committee recognized that indigency was a disease with economic, sociologic, medical and political causes which needed to be eradicated by specific treatment in order to rehabilitate the individual to independence. A merely supportive approach to the problems of indigence leads to an incurably chronic condition of indigence as a way of life with the individual completely dependent upon the state and free of responsibility.

The committee recommended establishment of a uniform system of hospitalizing the acutely ill indigent by creation of a state and county matching fund out of which payments might be made directly to hospitals for the costs of caring for certified indigent; the smaller government (county) units would be encouraged to assume the major administrative and financial responsibility. Plans for care of the chronically ill and outpatient care of indigent were to be made after additional study. It was assumed the doctors of Florida would continue their services to the acutely ill, hospitalized indigent persons without charge, pending further study.

The recommendations were enacted into law by the Florida Legislature and became effective 1 January 1956. The program is administered through the county health officers and is flexible enough to meet the individual problems of each county. The health officer may delegate determination of indigence and other duties to qualified agencies. A one page form is used by the physician, who makes the diagnosis and refers the patient for hospital admission, by the social worker who determines indigence, and by the hospital for the bill.

Sixty-four of Florida's sixty-seven counties (97% of the population) voluntarily joined the statewide program to provide hospital care for the acutely ill indigent and the plan has functioned to the satisfaction of patients, hospitals and physicians. No one is denied hospital care who needs it.

With a yearly expenditure of approximately \$2,000,000 in state funds and \$2,000,000 in



county funds about 22,000 indigent are provided hospital care each year at an average hospital daily cost of \$20 and average hospital stay of 9.6 days; 46% have been public assistance recipients and 54% medically indigent. Twenty-six per cent were aged 65 and over. In only 10% of the admissions was there participation in payment to the hospital by family, charitable organizations, or insurance.

As the 1959 Florida Legislature found itself hard pressed for funds, the state appropriation for hospital care of public assistance recipients was made to the State Board of Health with instructions to supplement it with federal matching funds.

Although we are of the opinion that indigent care programs should be administered and financed as close to home as possible, the doctors of Florida have cooperated in advising the State Board of Health and State Welfare Department on a contract by which hospital care can be provided welfare recipients using state and federal funds in the same program of hospital care for the medically indigent using state and county funds as previously described.

However, the arrangements have not been easy due to the rigidity in federal regulations, as interpreted by the State Welfare Board, concerning the use of federal matching funds. One might almost conclude that the law and regulations were so written as to require medical care to be completely administered by welfare agencies and to exclude the medically oriented agencies and medical doctors from participation in the planning or administration of the health programs. The proposed legislation under consideration would vastly broaden health care under the Department of Welfare and another broad health program has been proposed to the Congress in an expansion of rehabilitation activities under the Department of Education.

Continuing their study on the problems of medical care, the second Citizens Medical Committee on Health appointed by the Governor recently made the following pertinent recommendations:

1. For the extension of the benefits of health insurance: through every practicable channel encourage the development and promote the use of voluntary low cost health insurance which will extend benefits to the aged and cover long term illnesses.

2. For reduction in the costs of hospital care

in long stay illnesses: the encouragement of the construction and operation of "limited service hospitals" in close proximity to major general hospitals to promote early transfer of patients from general hospitals and to provide efficient long term care of chronic diseases.

3. For more adequate nursing home care: legislative authorization for the Welfare Board to implement a program to pay the cost of nursing home care for public assistance recipients, this to be provided by county, state, and federal matching funds; also encouragement of the active participation of religious groups in developing and maintaining nursing home facilities.

4. For accessible and economical medical care for the aged and those with chronic illnesses: the expansion of present outpatient clinics and the organization of additional clinics to meet the medical needs of the indigent aged and the chronically ill, with such services coordinated with and fully utilized in expanding and strengthening the intern and resident medical training program.

5. For home care of the aged and the chronically ill: within the realm of existing health agencies expand and modify community nursing programs so the services of visiting nurses will be widely available and existing welfare agencies to sponsor foster home care, and homemaker and friendly visitor services.

6. For the provision of medical services to recipients of public welfare: the assignment of responsibility for medical and health matters to the medically-directed health agency with the evolution of appropriate inter-agency administrative relationships.

7. For increased state and local responsibility for medical care of the indigent program: use every possible influence to obtain a release to the states of tax sources now utilized by the federal government for the support of health services with planning and administrative responsibility centered as close as practicable to those served.

In accordance with these recommendations the Florida Legislature this year amended the Hospital Service for the Indigent law to include outpatient medical care and development of ancillary medical and nursing outpatient services and implementation is proceeding as rapidly as available funds permit.

The Florida Medical Association has created the Florida Medical Foundation for the purpose of providing medical services for care of the



indigent, postgraduate medical education, and research. This organization can work closely with the State Board of Health and State Welfare Department in providing and coordinating these medical services.

The fabulous advances made in the field of hospital and medical insurance in recent years attest the responsibility the people of this country feel to individually provide medical care for themselves. In 1958, a survey revealed that 63% of the population have health insurance, but only 35% of those aged 65 and over were insured. Led by Blue Shield and Blue Cross, insurance companies in Florida are improving their insurance coverage and are offering medical and hospital insurance on an individual basis to the aged. This is the American way.

In Florida, no one who needs it goes without hospital care. Voluntary health insurance is being rapidly expanded and is the answer for the majority. Health needs of the indigent are provided for by medically directed statewide programs.

Only the practicing medical doctor can prevent the abuses necessary to insure the economical and effective operation of these medical insurance and indigent care programs. The initiative of the medical profession must be encouraged to assume the responsibility of these efforts, but it would be thwarted by government programs such as the proposed legislation.

Florida is well on the way to finding answers to the economic problems of modern medical care through novel applications of traditional principles of individual responsibility in a cooperative manner.

We do not need additional federal legislation to solve these problems, but we do need a relaxation of the rigid regulations directing health activities under federal welfare control, and we do need release of certain federal taxes collected in our state so that these funds might be applied to solving our particular health problems in our way.

#### **\*Traditional Principles**

Medical care has been a matter of individual responsibility of both the patient who seeks the care and the doctor who administers it. This historical principle of medical economy as practiced in our country has produced the highest quality of medical care more generally available than in any other nation in the world today or in history.

Those governments which, in recent years, assumed the obligation to provide medical care for their citizens have, as a result, diminished the quality, increased the cost, and thwarted medical progress in comparison to the achievements of medical care in the United States provided under the principle of bilateral individual responsibility.

Traditionally, the individual physician has assumed the obligation to provide medical care to those who request his services regardless of their ability to pay. Fulfillment of this responsibility depends upon the physician's abilities and limitations of the environment. As the need for hospital facilities to provide good modern medical care for serious illness has increased, it has become more difficult for the individual physician, especially in the urban environment, to provide medical care for those unable to pay the costs of the facilities, medications and services required. Local and state governments in a variety of manners have assumed some of these costs for the indigent sick. More recently, by amendments to the social security law, the federal government has sought to standardize medical care for the indigent as a function of the department of welfare and assume the bilateral responsibility of medical care for these citizens through the medium of federal-state matched payments to "vendors" of medical services to public assistance recipients.

The proposed legislation under consideration, H.R. 4700, would assume for the federal government the responsibility of providing medical services for a segment of the population without the requirement of indigence. With only a change in age limits the entire population would be relieved of this vital individual responsibility and the services of the medical profession would be a part of the government welfare program.

Thus a program of government medical care would be achieved with little promise of providing a better quality or less costly medical care for the people of this country. Admittedly, the bookkeeping would be streamlined, but at what cost in individual liberty inevitably lost when responsibility is surrendered! Can a government founded on the sovereignty of the people afford so great a loss of individual responsibility which is the foundation of sovereignty?

Laws and regulations must not be created that will thwart exercise of the fundamental American medical economic principle of bilateral responsibility for medical care in solving today's health problems as they have so successfully achieved major medical advances in the past.

The commerce and institutions developed in the solution of today's health problems by voluntary health insurance and medically directed indigent care programs would strengthen the economy and our most vital national resource, the initiative of individual responsibility. Government-financed welfare-directed free medical care programs will tax our economy and weaken the sovereign power of the people.

#### **LETTER TO THE EDITOR**

August 19, 1959

Dear Sir:

I read your State News Items with interest and thought perhaps information on my most recent trip abroad might also be of interest.

On June 9, 1959 I flew to Athens, Greece, to attend the Mediterranean Conference on Rehabilitation under the high patronage of H. M. Queen of the Hellenes. There I presented two lectures on orthopaedic and rehabilitation subjects, including the demonstration of the polyurethane plastic called Ostamer used in the treatment of osseous lesions and also lectures and demonstrations on the operative treatment of osteoarthritis of the hip joint, with emphasis on osteotomy. These lectures were given at the orthopaedic clinic of the University of Athens and the Asclip-

lien Voulais Hospital, both under the direction of Professor Th. Garofalides. Side trips in Greece included visits to Corinth and the Open Air Theatre at Epidarus; other trips of course included the Acropolis.

Thereafter, I spent four days in Istanbul, Turkey, giving one lecture in the Department of Orthopaedic Surgery. Side trips there included the Princess Isles in the Sea of Marmara. One must cross only the Bosphorus to reach Asia Minor where I visited a small village called Kadiköy.

I went by air to Vienna for a few days and then drove into Yugoslavia. After giving two lectures at the University of Slovenia in Ljubljana, I drove back to Graz, Austria, where I visited the orthopaedic clinic and the large rehabilitation center. Crossing the border into Hungary at Köszeg, I drove to Gyor and on to Budapest to lecture for several days at the Budapest Orthopaedic Clinic, which is well directed by the Chief, Dr. A. Glauber. I also visited the State Rehabilitation Center for the Treatment of Cerebral Palsy and saw one of the finest demonstrations of group therapy that I have ever witnessed, presented under the direction of Professor Andreas Petö.

From Budapest I drove to Bratislava, the capital of Slovakia. Here two lectures were given in the Komensky University in the Department of Orthopaedic Surgery, which is directed by Professor Jan Cervenansky, well known for his work on alkaptonuria.

In Brno, the capital of Moravia, I then spent several days visiting orthopaedic and rehabilitation clinics and had several nice lectures and visits with Professor Bedrich Frejka, who will soon celebrate his seventieth birthday. His work with congenital hip diseases is internationally known; many of us use the Frejka pillow in the treatment of early congenital hip disease and displacement.

Proceeding by automobile to Prague, I gave several lectures in the clinic of the late Professor Zahradnicek, now under the direction of Professor Miroslav Jaros. My first visit to Czechoslovakia was in 1956; I renewed old acquaintances and saw all of the living corresponding members of the American Academy of Orthopaedic Surgery.

Leaving Prague, I proceeded towards the Czechoslovak-German border by way of Pilzen. One does not go through Pilzen without spending

at least a half day touring the famous Pivo Vary, or Pilzen Brewery. One must imbibe at least a liter of this famous brew; you have the choice of the 12 or 18 per cent alcoholic content. More than one of these full steins would necessitate your remaining for at least a night in one of the well known Pilzen hotels.

En route to Regensburg, Germany, I visited several orthopaedic clinics, and before coming to Munich, I stayed one day in Dachau. There I visited the infamous Krematorium. I can not adequately describe my reactions and will withhold my opinions.

My journey continued on to Innsbruck, the most beautiful Austrian city in the Tyrol, where I visited my daughter, who was staying there with an Austrian family for the summer. From there I drove to Lichtenstein and then to Zurich, Switzerland, where I spoke before the Association for Traumatology and the Treatment of Fractures and was elected to active membership in this Swiss society. I remained there four days touring the country with a well known traveling surgeon who operates in 12 hospitals. Scientifically, this was the most interesting part of my trip.

The trip home by air was uneventful. In 38 days I had covered some 20,000 miles or more, of which I drove 2,500. Since 1948 I have visited 32 countries; this was my ninth trip to the European continent and the fifth to the eastern countries. It was, however, my first visit to Hungary, and never have I been treated with greater hospitality. Last summer I visited Bulgaria and in 1956 I spent one month in Russia. I have been in Poland and Czechoslovakia on two occasions and have visited Yugoslavia five times. Of all my trips, I think that this perhaps was the most interesting for with the experience of a seasoned traveler I could easily perceive those signs which are necessary to feel the pulse of a country. At no time were restrictions imposed upon me anywhere and I had freedom to drive as I chose.

American surgeons can travel practically anywhere in the world, as you can see by the outline of my itinerary. Countries such as Bulgaria, Hungary, Czechoslovakia and Yugoslavia will invite American surgeons to participate in scientific programs. On many occasions, however, these invitation either have not been acknowledged or engagements usually have not been fulfilled after acceptance of the invitations. Such refusals or neglect are oftentimes interpreted as insults and unless the people are certain the invita-



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\*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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tions will be accepted and the guest will present himself, they are seldom extended.

Sincerely yours,  
Irwin S. Leinbach, M.D.

July 24, 1959

Dear Dr. Richardson:

The Medical and Chirurgical Faculty of the State of Maryland (Maryland State Medical Association) has, for many years, expressed concern over the inroads the Veterans Administration Hospitals are making into the realm of the private practice of medicine. In order to combat the fantastic growth of treatment of non-service connected ailments of veterans, the Faculty has passed many resolutions condemning this practice and urging that something concrete be done to curtail or stop this insidious growth.

The Faculty's House of Delegates at its 1959 Annual Meeting passed a resolution that all component medical societies of the American Medical Association be contacted and urged to support the Faculty's stand in this respect.

As a result of a letter sent to every A.M.A. component medical society, eleven answers have been received all in the affirmative.

It is anticipated that other societies will also

reply in the affirmative and that full support to this projected concerted action will be forthcoming from them as well.

I sincerely hope that you will see fit to publish this letter and alert your readers to the steps that are being contemplated along these lines, not the least of which is the hope that an appropriate resolution will be introduced in the A.M.A.'s House of Delegates at its clinical session in Dallas in December.

Sincerely,  
Amos R. Koontz, M.D., Chairman  
Committee on Veterans' Medical Care

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### Realism

The American doctor's eternal struggle to preserve his professional freedom is now being waged in a new arena. Ten years ago, the big question was whether medicine could develop a viable prepayment program by its own voluntary effort, aided by labor, management and local community leaders. The alternative then was the threat of compulsory health insurance, governmentally operated and controlled.

In some segments of our economy today, both labor and management are showing a lively interest in providing medical care through a "closed panel" program, in which free choice would be limited, fee-for-service would be replaced by salaries or capitation payments, and the direct personal responsibility of the physician would be subordinated by collective controls.

The American Medical Association has acknowledged the legitimacy of these alternative programs and the right of the patient to choose the pattern or plan through which he wishes to prepay his medical care. This is realism.

But it is also "REALISM" when physicians realize that ultimately the traditional pattern of medical service can be preserved only if patients find that it meets their vital needs better than any other program. *Again* Blue Shield must offer the widest possible choice of programs as an economic partner to the private practice of medicine.

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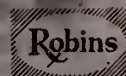
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Carpenter <sup>1</sup>	33	"marked" 26	6	1	—
Forsyth <sup>2</sup>	58	"pronounced" 37	20	—	1
Lewis <sup>3</sup>	38	"good" 25	6	—	7
O'Doherty & Shields <sup>4</sup>	17	"excellent" 14	2	1	0
Park <sup>5</sup>	30	"significant" 27	—	2	1
Plumb <sup>6</sup>	60	"gratifying" 55	—	—	5
<b>TOTALS</b>	<b>236</b>	<b>184</b> (78.0%)	<b>34</b> (14.4%)	<b>4</b>	<b>14</b>

- Highly potent—and long acting.<sup>1,2,3</sup>
- Relatively free of adverse side effects.<sup>1,2,3,5,6</sup>
- In ordinary dosage, does not reduce muscle strength or reflex activity.<sup>1</sup>

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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## OTHERS ARE SAYING

### At Last A Champion

A recent article in the *Ladies Home Journal*, by Dorothy Thompson, which was brought to my attention, should be refreshing to the medical profession, to say the least. Admittedly we are prejudiced in favor of such an article, but, in our opinion, nevertheless, it presents the most objective thinking and writing about the medical profession, its allied professions, and institutions, that we have encountered in a long time.

The medical profession has been belabored and criticized, with increasing frequency in the past years, as being calloused, inhuman, selfish, motivated only by the desire to make money, caring secondarily only for the health and welfare of their patients and the community in which they

live. Mrs. Thompson brings out that we should consider this to be a compliment. This may be true, but over a period of time, such compliments are apt to become an irritating abrasion, rather than a comforting rub, or a constructive massage meant to alleviate some of the underlying pathology.

There is no one, I think, more aware of our shortcomings than ourselves. The public expects, and justifiably so, the doctor to be more humane, compassionate, understanding, tolerant, and self-sacrificing than any of the other professions. Each year medicine is becoming more and more of a science. Unfortunately, and unnecessarily, there is a tendency to gradually lose some of the personal approach and the "art." This, however, is a trend of the times and not necessarily peculiar to the practice of medicine. Where is the kindly old grocery man who used to anticipate and deliver your grocery needs and give you the five-cent bag of candy when you paid the bill on Saturday night? The era of the "old-time practitioner" is past and by the same token the health needs of the people are being served better today than they were then.

Nevertheless, it is my feeling that we can and should pause in our headlong dash for scientific achievement in medicine and remind ourselves, the medical schools should remind their students, the nursing schools should remind their nurses, the hospital administrators should remind their employees, that people, no matter in what category, are human beings whose recovery, in the majority of cases, depends just as much on understanding and the "art" of medicine as all the advanced drugs, surgical techniques, and nuclear therapeutics in our armamentarium today.

*Robert P. Keiser, M.D., President  
Dade County Medical Association  
The Bulletin  
July 1959*

### And So It Is With Man

When the first adventurous blossom pushes its way out in the early spring, tempted by a rare warmth, there often comes a sudden chilling of the air. How alone, bereft and deserted this little messenger of life must seem! But if there should enter into its little heart a belief that it has come to serve a purpose—to cheer and bless, and make life serene and more abundant, would it not be comforted?

*(Continued on page 468)*

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References: 1. Seltzer, A.: M. Ann. District of Columbia 26:17, 1957.

2. Slaughter, D.: South Dakota J. Med. & Pharm. 1:425, 1940. **Wampole Laboratories, Stamford, Conn.**

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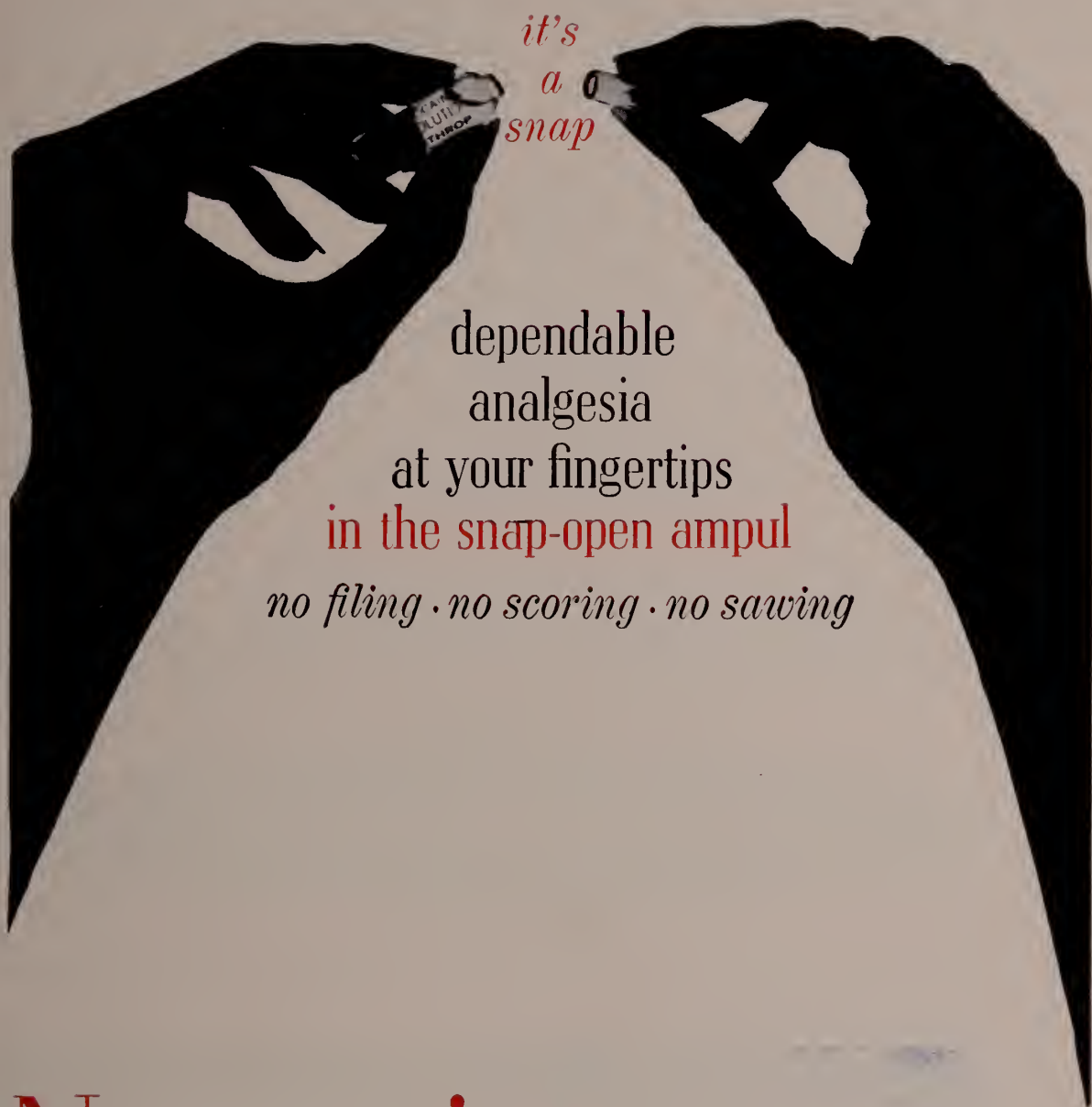
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(Continued from page 462)

What a snug feeling would come to it when it knew that it was a messenger, not of the cold of wintry winds, but of the warmth of the sun, bringing brightness and cheer to a desolate world!

And so it is with man—

Through tribulation and many hard things, if there dwells within the man the thought of a will to do and a purpose to serve, how courageous are his battlements, and how hopefully he bears his burdens, knowing that he is the messenger of usefulness and contentment.

*Author Unknown*

*Submitted by James R. McCain, M.D.*

*Monthly Bulletin Duval County Medical Society*

*April 1959.*

### STATE NEWS ITEMS

A five day seminar on Care of Premature Infants has been announced for November 16-20 at the Premature Demonstration Center, University of Miami School of Medicine, Jackson Memorial Hospital, Miami. Applications and additional information are available from the Bureau

of Maternal and Child Health, Florida State Board of Health, P. O. Box 210, Jacksonville.

Dr. Jere W. Annis of Lakeland has been appointed a member of the State Welfare Board for a term ending July 2, 1960 by Governor Leroy Collins.

Dr. Louis M. Orr of Orlando, President of the American Medical Association, was guest speaker for the Section on Urology of the 92nd annual meeting of the West Virginia State Medical Association held August 20-22 at White Sulphur Springs, Va. Dr. Orr's subject was "Use of Radioactive Au 190 in Carcinoma of the Prostate." He also addressed the final session of the House of Delegates.

Drs. John T. Benbow of Chattahoochee and William M.C. Wilhoit of Pensacola have been reappointed as members of the Council on Mental Health by Governor LeRoy Collins.

Dr. Joseph H. Lucinian of Coral Gables has been attending the Ninth International College of Radiology in Munich, Germany. While abroad,



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he visited in Switzerland, Holland, France and England.

Dr. Hugh M. Hill has been appointed assistant professor of obstetrics and gynecology at the College of Medicine, University of Florida, Gainesville. He formerly held a similar teaching position in the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine.

Dr. Edward W. D. Norton has been appointed professor and chairman of the Department of Ophthalmology at the University of Miami School of Medicine. The recently established department was formerly a division of the Department of Surgery. Dr. Norton located in Miami in 1958 as associate professor of ophthalmology.

Dr. Leon S. Eisenman of Hialeah has been appointed a member of the board of directors of the Welfare Planning Council of Dade County representing the city of Hialeah.

Dr. William J. Clough of Tarpon Springs has been on an extended trip through France, Italy,

Switzerland and Austria. In Vienna, Dr. Clough took postgraduate work at the American Medical Hospital.

Dr. Francis W. Glenn of Coral Gables, and Drs. Lee J. Cordrey and Joseph J. Ruskin of Tampa are among the Florida physicians participating in the program of the 20th annual meeting of the American Fracture Association being held November 1-4 at the Roosevelt Hotel in New Orleans. The titles of Dr. Glenn's addresses are "Fractures of the Elbow Area" and "Supracondylar Fractures of the Humerus." Dr. Cordrey will discuss "Fracture of Carpal Bones" and "Carpal Navicula Fractures" and Dr. Ruskin "Metatarsal Fractures."

Dr. J. Brown Farrior of Tampa participated in the program of the recent 25th Postgraduate Medical Assembly of South Texas held in Houston. The subject of his address was inner ear surgery.

Dr. Robert L. Tolle of Orlando, president of the Orange County Medical Society, has announced that the 1960 Southeastern States Cancer Seminar will be held in Orlando. The date has not been decided upon. This will be the tenth biennial Seminar.

Dr. Louis M. Orr of Orlando, President of the American Medical Association, was honor guest at the president's reception of the Sixty-Fourth Annual Meeting of the Utah State Medical Association held September 16-18 at Salt Lake City. Dr. Orr was the feature speaker at the banquet following the reception.

Dr. Emmet F. Ferguson Jr. of Jacksonville represented the Jacksonville Area Chamber of Commerce in Moscow while on a recent trip abroad. Through the Chamber of Commerce in the Russian city, Dr. Ferguson had the opportunity to meet physicians and visit clinics, hospitals and institutes.

Dr. Egbert V. Anderson of Pensacola, president of the Escambia County Medical Society, and Dr. Clarence M. Sharp of Jacksonville, director of the Bureau of Preventable Diseases, Florida State Board of Health, participated as members of the panel for discussion of poliomyelitis at a recent public meeting in Pensacola.



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


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
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**Supplied:** Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

**References:** 1. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy 29:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. 38:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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## Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 395 applicants who took the examination of the Board, held June 22-23, 1959 in Miami Beach, 350 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 350 successful applicants follow:

- Abelson, Donald Samuel, New York (State U. Syracuse 1953)  
 Adickes, Edward James, Bal Harbour (NYU 1946)  
 Adlerberg, Howard Milton, Miami Beach (Chicago M. S. 1959)  
 Ainsworth, William Nicholson III, Atlanta, Ga. (Emory 1959)  
 Albritton, David Crockett, Spartanburg, S. C. (M. C. Ga. 1959)  
 Alecce, Paul Marion, Miami (Georgetown U. 1953)  
 Alexander, Gerald Laurence, Brooklyn (Duke 1955)  
 Ammons, Charlie Alfonzo, Tampa (Louisiana St. U. 1958)  
 Anderson, Harris Renard, Rockford, Ill. (Northwestern U. 1950)  
 Andrew, Samuel Edwards, Shreveport, La. (U. Tenn. 1940)  
 Arean, Victor Manuel, Gainesville (U. Madrid 1940)  
 Armstrong, Allan LeRoy, Tampa (U. Virginia 1949)  
 Arnold, John Ralston, Winter Garden (Emory U. 1959)  
 Ashcraft, John Randolph, Fort Lauderdale (Ohio St. U. 1948)  
 Asher, Harold, Atlanta, Ga. (Emory U. 1959)  
 Asrael, Gerson, Baltimore (U. Maryland 1959)  
 Babcock, Warren Wood Jr., Detroit (U. Mich. 1956)  
 Baekeland, Frederick, Miami (Yale U. 1958)  
 Ball, Thomas Prioleau Jr., College Park, Ga. (Emory U. 1958)  
 Bangasser, Edward Michael, Lancaster, N. Y. (Georgetown U. 1940)  
 Barrett, David Laun, Beaufort, S. C. (U. Louisville 1957)  
 Barrett, Warren Marshall, Jacksonville (Jefferson 1958)  
 Basinger, James Warren, Tampa (U. Arkansas 1958)  
 Bass, Robert Thomas, Miami Beach (Northwestern U. 1959)  
 Bass, Shelton Thomas, Charleston, S. C. (Bowman Gray 1953)  
 Batchelder, Theodore Laverne, Jacksonville (U. Kansas 1950)  
 Bayley, John Frederick, Memphis, Tenn. (U. Tenn. 1954)  
 Beach, William Roseboro III, Atlanta, Ga. (Emory 1959)  
 Beck, Howard James, Miami (U. Lausanne 1956)  
 Beehler, Cecil Cook, St. Petersburg (U. Miami 1959)  
 Belcher, William Thomas Jr., Decatur, Ga. (Emory U. 1959)  
 Bennett, Garland Prior Jr., Decatur, Ga. (Emory U. 1959)  
 Beran, Joseph James, Waterloo, Ia. (Marquette U. 1950)  
 Besse, Byron Earl Jr., Tampa (Jefferson 1950)  
 Bicknell, Donald Roy, West Palm Beach (Tufts 1955)  
 Biddlestone, William Robert, Willowick, Ohio (U. Tenn. 1948)  
 Bleich, Howard Leslie, Boston (Emory U. 1959)  
 Block, Rodney Alton, Orlando (Emory U. 1959)  
 Bloom, William Herman, Granville, N. Y. (U. Buffalo 1948)  
 Blum, Robert Stuart, Minneapolis (U. Rochester 1959)  
 Bonk, George, No. Miami Beach (U. Illinois 1958)  
 Bosco, Julius Anthony Sisto, New Orleans (New York M. C. 1953)  
 Bowen, Edward Gene, Lakeland (Duke U. 1958)  
 Bowers, John Alfred, Memphis, Tenn. (M. C. Ga. 1956)  
 Bowman, James Preston II, Opa Locka (Emory U. 1959)  
 Brice, Anton Melville Jr., Decatur, Ga. (Emory U. 1959)

(Continued on page 478)

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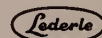
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## case profile no. 2840\*

A 55-year-old man complained of a painful, very stiff neck on the left side. There was marked muscle spasm that seemed to involve primarily the trapezius muscle. He had a severe headache, with the pain radiating down the left side of the neck to the shoulder. There were no other findings on physical examination and results of routine laboratory tests were normal.

Trancopal was prescribed in a dosage of 200 mg. q.i.d. The first and second dose of Trancopal gave only moderate relief. However, after the third dose, there was marked relief of the stiffness of the neck, as well as the headache and shoulder pain.

After the fourth dose, medication was gradually decreased and was discontinued on the sixth day. One week later, the patient had moderate recurrence of the torticollis, and Trancopal was again prescribed in doses of 200 mg. q.i.d. The patient obtained complete relief in one day and no further treatment was required.

## for torticollis



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for anxiety and  
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## case profile no. 3382\*

A 35-year-old woman, a professional model, had an acute, severe attack of anxiety. She was irrational and unable to eat, and was very restless.

Initial medication consisted of aspirin with codeine and later meprobamate. Neither was effective, and the patient's condition became worse. She had to be hospitalized because of the marked anxiety. Trancopal was then prescribed in a dosage of 200 mg. q.i.d., in addition to bed rest.

After the second dose of 200 mg. of Trancopal, the patient became calm and rational, and was able to eat. The dosage of Trancopal was gradually reduced to 100 mg. q.i.d. on the fourth hospital day, after which the patient was discharged and was able to return to her normal occupation.

*\*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.



# *THE FIRST TRUE "TRANQUILAXANT"* **Trancopal**

**potent MUSCLE RELAXANT**  
**effective TRANQUILIZER**

## Indications:

### Musculoskeletal<sup>1</sup>

Neck pain (torticollis, etc.)  
Low back pain (lumbago, etc.)  
Bursitis  
Rheumatoid arthritis  
Osteoarthritis  
Disc syndrome  
Fibrositis  
Ankle sprain, tennis elbow, etc.  
Myositis  
Postoperative muscle spasm

### Psychogenic<sup>1</sup>

Anxiety and tension states  
Dysmenorrhea  
Premenstrual tension  
Asthma  
Angina pectoris  
Alcoholism

**Dosage:** Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours. The higher dosage is recommended for the treatment of patients in the acute stages of painful musculospastic conditions, and anxiety and tension states. Children (5 to 12 yrs.), 50 mg. three or four times daily.

### Supply:



Trancopal Caplets®

100 mg. (peach colored, scored), bottles of 100.

**New  
strength**



Trancopal Caplets

200 mg. (green colored, scored), bottles of 100.

"Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."<sup>2</sup>

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."<sup>3</sup>

" . . . Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states."<sup>4</sup>

1. Collective Study, Department of Medical Research, Winthrop Laboratories.
2. Lichtman, A. L. (N.Y. Polyclinic M. Sch. & Hosp.): *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958.
3. Mullin, W. G., and Epifano, Leonard (Long Island College Hosp.): *Am. Pract. & Digest Treat.* To be published.
4. Ganz, S. E. (New York, N. Y.): *J. Indiana M. A.* 52:1134, July, 1959.

**Winthrop** LABORATORIES  
New York 18, New York





Each tablet contains: Iron (Ferrous Sulfate Exsiccated 194 mg.), 58 mg.; Dioctyl Sodium Sulfosuccinate, 100 mg.; Vitamin A, 6000 U.S.P. Units; Vitamin D, 400 U.S.P. Units; Vitamin B<sub>1</sub> (Thiamine Mononitrate), 5 mg.; Vitamin B<sub>2</sub> (Riboflavin), 5 mg.; Vitamin B<sub>6</sub> (Pyridoxine HCl), 2 mg.; Vitamin B<sub>12</sub> Activity (Cobalamin Conc.), 2 mcg.; Vitamin C, 100 mg.; Folic Acid, 0.25 mg.; Niacinamide, 20 mg.; Calcium Pantothenate, 5 mg.; Calcium (Calcium Carbonate), 150 mg.; (Phosphorus free formula).

**strength and vitality...**  
**freedom from constipation**



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**prenatal dietary supplement**  
**high iron content in a potent nutritional formula**  
**counteracts prenatal constipation**  
**sensibly packaged in re-usable nursing unit**  
**one-a-day dosage convenience**

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the first nitrofuran  
effective orally  
in systemic bacterial infections

**ALTAFUR**<sup>T. M.</sup>  
brand of furaltadone

*Effective clinically in upper respiratory infections,  
pneumonias, soft tissue infections, bacteremia/septicemia,  
osteomyelitis, wound infections and pyodermas.*

Effective in vitro against the following organisms (isolated from clinical infections listed above) :

Organism	Sensitive	Resistant	% Sensitive
Staphylococci*	181	1	99.4
Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
Coliforms	34	3	91.8
Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

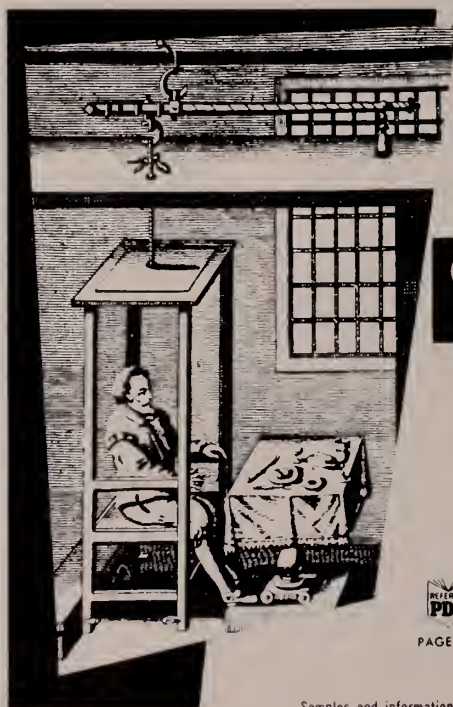
\*Includes many strains resistant to antibiotics.

As with all nitrofurans in years of extensive clinical use, there is little or no development of bacterial resistance with ALTAFUR.

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(Continued from page 474)

- Britton, John Bayard, Jacksonville (U. Va. 1949)  
 Brokaw, Bergon Frank, Miami (U. Miami 1959)  
 Brook, Jack, Portsmouth, Va., (New York M. C. 1953)  
 Brown, Fred David, Jacksonville (U. Maryland 1959)  
 Brown, Garland Richard, Muncie, Ind. (Jefferson 1958)  
 Brown, Robin Cotten, New Orleans (Tulane 1959)  
 Buckingham, John Ladd, Atlanta, Ga. (Bowman Gray 1959)  
 Burack, Bernard, Riverdale, N. Y. (Creighton U. 1949)  
 Burpee, Claude McLeod, Tampa (M. C. Ga. 1956)  
 Calman, Carl Hubert David, St. Louis (St. Louis U. 1950)  
 Cameron, William Brooks, Memphis, Tenn. (U. Tenn. 1952)  
 Cammarata, John Mario, Key West (Boston P&S 1947)  
 Campbell, Arthur Samuel, Mannheim, Germany (New York Med. 1954)  
 Cano, Rene Aurelio, Miami (U. Havana 1946)  
 Cantor, Jack Leon, Miami Beach (U. Va. 1932)  
 Carle, Terry V., Emporia, Kan. (U. Kansas 1958)  
 Carter, Harvey Pratt, Ocala (Emory U. 1959)  
 Castleberry, Barbara Cordeva, Wauchula (M. C. Ga. 1957)  
 Catasaros, Dimitrios Christy, Coral Gables (U. Zurich 1956)  
 Chamberlain, Eugene Charles Jr., Fort Lauderdale (U. Miami 1958)  
 Christensen, Ray K., Weirsdale (U. Colo. 1958)  
 Christie, John Norton Jr., Washington, D. C. (Duke U. 1957)  
 Citron, Adolph Edward, Baldwin, N. Y. (Boston U. 1930)  
 Civan, Mortimer Mordecai, Brooklyn (Columbia U. 1959)  
 Clark, Richard Barnes, Tampa (U. Arkansas 1958)  
 Cleveland, Willard Henry, Buffalo (U. Buffalo 1935)  
 Cogen, Stephen Thomas, Brooklyn (New York Med. 1959)  
 Cohen, Edward Philip, Bethesda, Md. (Washington U. 1957)  
 Cohen, Raymond, Miami (U. Lausanne 1957)  
 Cole, Henry Byars, Tallahassee (U. Tenn. 1956)  
 Comezanas, Victor Manuel, Miami Beach (U. Havana 1953)  
 Cooley, James Keats, Herkimer, N. Y. (Coll. Med. Evang. 1958)  
 Cooper, Edward Irvin, Philadelphia (Jefferson 1957)  
 Courts, Andrew Johnson, Miami (U. No. Carolina 1958)  
 Cowan, Thomas Warner, Houston, Texas (U. Md. 1955)  
 Cragg, Paul Francis, Sarasota (Emory 1959)  
 Culberson, Jerry D., St. Petersburg (Ohio St. U. 1958)  
 Cullen, Stanley Irwin, St. Petersburg (U. Miami 1959)  
 Culpepper, George Harlin Jr., Orlando (U. Miami 1959)  
 Curtiss, Charles Edward, Winter Haven (Washington U. 1953)  
 Cypress, Eileen, Miami (U. Miami 1959)  
 Daniel, Thomas Martin, Jacksonville (U. Miami 1959)  
 Deep, William Daniel, Richmond, Va. (M. C. Va. 1959)  
 Deitch, Ronald Stuart, Washington, D. C. (G. Washington U. 1958)  
 DeLaughter, George Dewey Jr., Durham, N. C. (Duke U. 1954)  
 Delman, Martin, Jamaica, N. Y. (St. U. New York 1958)  
 Dillard, Gregory Morris Jr., Emory U., Ga. (Emory U. 1959)  
 Dimon, Joseph Homer III, Columbus, Ga. (Columbia U. 1953)  
 Dominguez, Gerald Henry, Tampa (Tulane 1959)  
 Doyle, Richard Stewart, Jackson, Miss. (U. Tenn. 1954)  
 Drake, Ellery Theodore, Williamson, W. Va. (Harvard 1942)  
 Eckert, William Gamm, Tampa (NYU 1952)  
 Ehringer, Gerald Lawrence, Jacksonville (Tulane 1956)  
 Fissman, Robert Carleton, Winter Haven (Indiana U. 1957)  
 Elliott, Larry Paul, Gainesville (U. Tenn. 1957)  
 Engstrom, George Alfred, St. Petersburg (Duke 1959)  
 Erde, Allan, Jacksonville (U. Penn. 1959)  
 Escalante, Carlos Cartaya, Tampa (U. Miami 1959)



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Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.

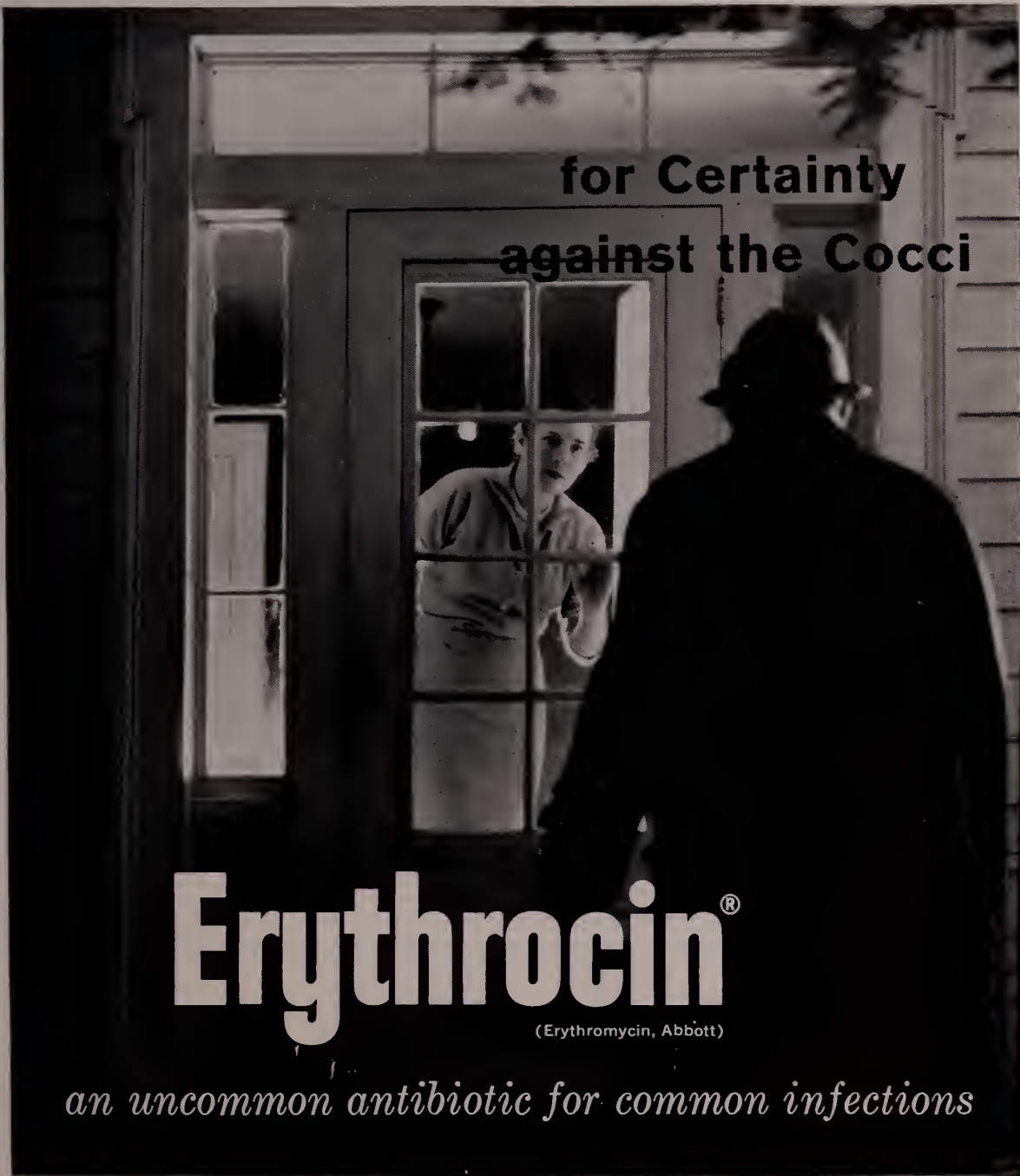


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- Evenhouse, Henry John, Orlando (Northwestern U. 1956)  
 Fernandez, Anthony Alvaro, Tampa (U. Miami 1958)  
 Feyer, Horst Walter, Miami (Johannes Guttenberg U. 1950)  
 Fisher, Grant Tracy, Lackawanna, N. Y. (U. Buffalo 1925)  
 Fisher, John Adam, Dunnellon (U. Miami 1959)  
 Fitton, Richard Howorth Jr., Amarillo, Tex., (Boston U. 1954)  
 Flavan, David Brislin, Venice (St. Louis U. 1927)  
 Floyd, Richard Dudley, Durham, N. C. (Yale 1952)  
 Flynn, Emmett William Jr., Tallahassee (Tulane 1959)  
 Foley, Michael Joseph, Clarksburg, W. Va. (U. Maryland 1952)  
 Foley, Philip James, Chicago (Northwestern U. 1951)  
 Forbes, James Davis, Ocala (Emory U. 1959)  
 Fortner, Billy Wilton, Tampa (Med. Coll. So. Carolina 1958)  
 Fox, Frederick Jay Jr., Clermont (U. Penn. 1959)  
 Frank, Paul Emerson, Philadelphia (Jefferson 1956)  
 Freier, Eugene Herman, Orlando (U. Michigan 1958)  
 Friedman, Alan Jay, Brooklyn (Harvard 1959)  
 Fuller, Henry Jr., Lakeland (U. Miami 1959)  
 Furr, Glen Eugene, Fort Walton Beach (U. Texas, Southwestern M.S. 1956)  
 Fuzzard, James Scott, Atlanta, Ga. (Emory U. 1959)  
 Gallo, Henry Dario, San Francisco (U. Miami 1959)  
 Galloway, Dolph Vernon, Daytona Beach (U. Tenn. 1925)  
 Gardy, Harvey H., Hollywood (Tulane 1959)  
 Garner, Ronald Smith, Sanford (U. Miami 1959)  
 Gibbs, Donald Charron, Miami (U. Miami 1959)  
 Gilbert, Michel George, Hollywood (NYU—Bellevue 1952)  
 Glass, Frederick William, Winston-Salem, N. C. (Bowman Gray 1950)  
 Glass, Roy Seymour, Miami Beach (U. Geneva 1955)  
 Godbold, Wayne Lewis, Winter Garden (Emory U. 1959)  
 Golden, Boris Albert, Niagara Falls, N. Y. (U. Buffalo 1940)  
 Goldfield, Elton Gordon, Miami (U. Miami 1959)  
 Goodman, Harold, Chicago (U. Illinois 1949)  
 Gorman, Jerome Davis, Lakeland (Georgetown U. 1959)  
 Green, Causey Stanton, Hempstead, N. Y. (U. Miami 1959)  
 Greenberger, Alex Mordecai, Coral Gables (Chicago M. S. 1954)  
 Greer, Pedro Jose, Miami (U. Madrid 1957)  
 Griffin, Richard Madison, Decatur, Ga. (Emory U. 1959)  
 Hadden, Edwin Eugene Jr., Madison (U. Miami 1959)  
 Hagedorn, Clem William, Miami (U. Nebraska 1947)  
 Hale, William Easley, Aldan, Pa. (M. C. Virginia 1958)  
 Hamilton, Paul Bunker, Miami (So. Western M. S. U. Texas 1958)  
 Hardman, William Miller, Lake Wales (Emory U. 1959)  
 Harris, Allan Harvey, Cleveland (U. Miami 1959)  
 Haswell, Forrest Moseley, Jacksonville (U. Rochester 1941)  
 Hausman, Sanford Albert, Brooklyn (N.Y.U. 1959)  
 Hawkins, Edith Petrie, Decatur, Ga. (Emory U. 1959)  
 Hawkins, Walter Rex, Decatur, Ga. (Emory U. 1959)  
 Hayes, James Franklin Jr., Jacksonville (U. Tenn. 1958)  
 Heaton, Wendell Carlos Jr., Tallahassee (U. Miami 1959)  
 Hennessey, Thomas Crompton, St. Petersburg (New York M. C. 1958)  
 Hildebrandt, Richard John, Fort Lauderdale (Duke U. 1959)  
 Hill, Gordon Edmond, Plantation (St. U. New York 1956)  
 Hinckley, Ralph Herrick, Belmont, Mass. (Harvard 1957)  
 Hines, John David, Coral Gables (Bowman Gray 1959)  
 Hochberg, Bernard Marty, Atlanta, Ga. (Emory U. 1959)  
 Hogle, Glen Sanford, Troy, Ohio (U. Cinn. 1951)  
 Holly, James Jr., Winter Park (U. Miami 1959)  
 Hunter, Burke Merren, Miami (U. Miami 1959)  
 Jacobs, Daniel Murray Jr., Daytona Beach (Duke U. 1959)  
 Jacobs, Warren Allan, Miami Beach (Louisiana St. U. 1958)

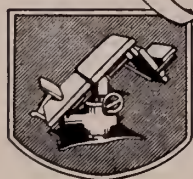
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Mysteclin-V Capsules (per capsule)	250	250,000
Mysteclin-V Half-Strength Capsules (per capsule)	125	125,000
Mysteclin-V Suspension (per 5 cc.)	125	125,000
Mysteclin-V Pediatric Drops (per cc. — 20 drops)	100	100,000

References: 1. Dowling, H. P.: Postgrad. Med. 23:594 (June) 1958. 2. Gimble, A. I.; Shea, J. G., and Katz, S.: Antibiotics Annual 1955-1958, New York, Medical Encyclopedia Inc., 1956, p. 678. 3. Long, P. H., in Kneeland, Y., Jr., and Worts, S. B.: Bull. New York Acad. Med. 33:552 (Aug.) 1957. 4. Rein, C. R.; Lewis, L. A., and Dick, L. A.: Antibiotic Med. & Clin. Ther. 4:771 (Dec.) 1957. 5. Stone, M. L., and Mersheimer, W. L.: Antibiotics Annual 1955-1958, New York, Medical Encyclopedia Inc., 1956, p. 862. 6. Campbell, E. A.; Frigot, A., and Dorsey, G. M.: Antibiotic Med. & Clin. Ther. 4:817 (Dec.) 1957. 7. Chamberlain, C.; Burros, H. M., and Borromeo, V.: Antibiotic Med. & Clin. Ther. 5:521 (Aug.) 1958. 8. From, P., and Aill, J. H.: Antibiotic Med. & Clin. Ther. 5:839 (Nov.) 1958.

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Squibb Quality —  
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- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

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- More specific than salicylates
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**SOMA** has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

**ACTS FAST.** Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

**NOTABLY SAFE.** Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

**EASY TO USE.** Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

**SUPPLIED:** Bottles of 50 white coated 350 mg. tablets.

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rapidly absorbed, producing fast, effective  
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entire day. Simple, single 0.5 Gm. daily dose  
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equivalent to 4 to 6 Gms. daily of previous  
sulfonamides. Does not produce renal  
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KYNEX is extremely low in toxic potential.<sup>2,3</sup>  
Cutaneous or other objective sensitivity  
reactions are rare, as demonstrated in a large  
scale evaluation of clinical toxicity.<sup>2</sup> Also minor  
subjective reactions are less likely to develop  
when the recommended dosage is used.<sup>2</sup>

Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial  
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1. Editorial, New England J. Med. 258:48, 1958.

2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.

3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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- Jacobson, Thomas Ernest, Wichita, Kan. (Howard U. 1956)  
 James, Marvin, San Francisco (N. Y. U. 1952)  
 Janssen, Benno Jr., Charlottesville, Va. (U. Virginia 1954)  
 Jenkins, Robert Henry, St. Petersburg (U. Miami 1959)  
 Johnson, Rufus Julian, Atlanta, Ga. (Emory U. 1959)  
 Jones, Franklin Delano, Jacksonville (Louisiana St. U. 1958)  
 Jones, Oliver Lee Jr., Miami (U. Miami 1959)  
 Julien, Bruce Alan, Miami Beach (U. Miami 1959)  
 Julien, Richard Arnold, Miami Beach (U. Miami 1959)  
 Kalenscher, Alan Jay, Bronx, N. Y. U. 1949)  
 Kandell, Howard Noel, Philadelphia (Tulane 1959)  
 Katzin, David Simon, Hollywood (U. Miami 1959)  
 Keller, Robert Henry, Grand Rapids, Mich. (Vanderbilt U. 1959)  
 King, Robert England, Bradenton (Emory U. 1959)  
 Kirkconnell, Waite Scott, Tampa (Tulane U. 1959)  
 Knight, Peter Oliphant IV, Tampa (Tulane U. 1959)  
 Knowles, Henry Angus McKinnon, Blountstown (U. Miami 1959)  
 Kupsinel, Roy, Fort Benning, Ga. (U. Miami 1959)  
 Kyler, Stephen Leo, Pittsburgh (U. Bratislava 1936)  
 Lancaster, Robert James, Lakewood, Ohio (St. Louis U. 1954)  
 La Rosa, Frank Joseph, Pitman, N. J. (Creighton U. 1937)  
 Lawton, George Marion, Pensacola (Wayne St. U. 1959)  
 Lazarra, Ralph, Tampa (Tulane U. 1959)  
 Leake, Frank, Baltimore (Johns Hopkins U. 1954)  
 LeDrew, Lloyd Silverthorn, Miami (Tulane U. 1959)  
 Lee, Joseph James, Louisville, Ky. (U. Louisville 1950)  
 Lee, Robert Elliott, Bethesda, Md. (U. Miami 1959)  
 Lehr, David Edward, New York (St. Louis U. 1954)  
 Leider, Irwin, San Antonio, Tex. (U. Miami 1959)  
 Levine, Sydney, Miami Beach (U. Miami 1959)  
 L'Heureux, Henry Peter Joseph Jr., St. Petersburg (Louisiana St. U. 1958)  
 Lindberg, Dale Kenneth, Uhrichsville, Ohio (Ohio St. U. 1953)  
 Linwood, Richard Arnold, Bellmore, N. Y. (Columbia U. 1959)  
 Lorincz, Andrew Endre, Gainesville (U. Chicago 1952)  
 Lowrey, Willa Dean, Miami (U. Miami 1959)  
 Loynaz, Nestor Augusto, Miami (U. Havana 1950)  
 Lustgarten, Barbara Sue, Hollywood (U. Miami 1959)  
 Lyle, William Bryan Jr., Jacksonville (Louisiana St. U. 1958)  
 MacDonald, Jack Watt, Tampa (Emory U. 1958)  
 MacGregor, Howard Street, Fairfield, Ala. (M. C. Georgia 1953)  
 McConville, Edward Benedict, Miami (Jefferson 1944)  
 McCranie, Peter Adams, Atlanta, Ga. (Emory U. 1959)  
 McHenry, Laudie Elbert Jr. Jacksonville (Vanderbilt U. 1953)  
 McKenzie, Doris, South Miami (U. Miami 1959)  
 McKenzie, William Joseph Jr., Atlanta, Ga. (M. C. Georgia 1956)  
 McKnight, William Joseph, St. Petersburg Beach (U. Pittsburgh 1957)  
 McRae, Barney English Jr., Jacksonville (U. Miami 1959)  
 Madison, James Buford III, Miami (Tulane U. 1959)  
 Magoon, Robert Cornelius, Miami (U. Miami 1959)  
 Mandel, Samuel S., Miami (Chicago M. S. 1958)  
 Markiewicz, Stanley Sextus, Coral Gables (Loyola U. 1926)  
 Marlowe, James Milton, Jacksonville (U. Miami 1959)  
 Massari, Franklin Stephen, Tampa (Georgetown U. 1958)  
 Mathews, Wayne Stanley, Decatur, Ga. (Emory U. 1959)  
 Matlin, Jordon Sanders, Miami (Leiden U. 1957)  
 Melton, James David Jr., Atlanta, Ga. (Emory U. 1959)  
 Menzies, Donald Stuart Jr., Sarasota (U. No. Carolina 1959)  
 Meyer, Roger Allen, Jacksonville (U. Minn. 1958)  
 Michaelos, Louis John, Atlanta, Ga. (U. Miami 1959)  
 Miller, Daniel Herzl, Miami Beach (U. Miami 1959)  
 Miller, Donald Wesley, Grand Forks, N. D. (U. Nebraska 1938)



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**OPTIONAL SCALES**  
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## CASE HISTORY OF AN ARTHRITIC

Age: 55

Sex: Male

Race: White

Diagnosis: Rheumatoid arthritis.

Previous Therapy:

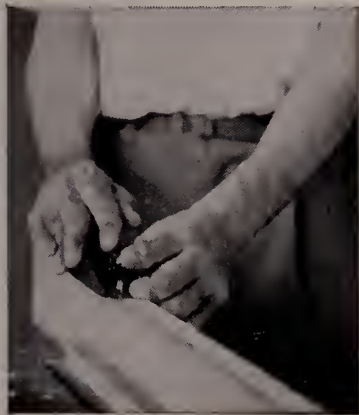
40 mg. triamcinalone per day.

Complicating States:

Duodenal ulcer, steroid intoxication.

Current Therapy: ARTHROPAN Liquid.

Results: The patient improved on ARTHROPAN and "...is now on Choline Salicylate [ARTHROPAN] alone and has returned to work."<sup>1</sup>



SUPPLIED: 8 and 16 oz. bottles.

Each ml. of ARTHROPAN Liquid contains

174 mg. of Choline Salicylate.

Each teaspoonful (5 ml.) contains 870 mg.

of Choline Salicylate.

1. Clark, G.M.: Personal Communication, 1958.

**ARTHROPAN**<sup>T.M.</sup>  
BRAND OF CHOLINE SALICYLATE  
LIQUID



*The Purdue Frederick Company*

DEDICATED TO PHYSICIAN AND PATIENT SINCE 1892  
NEW YORK 14, N. Y. | TORONTO 1, ONTARIO

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- Miller, Jordan Emanuel, Miami Beach (U. Tenn. 1958)  
 Miller, Robert Rham, Franklin Sq., N. Y. (New York M. C. 1959)  
 Mitchell, Calvin Harrison, Durham, N. C. (Duke U. 1933)  
 Mitchell, William Clay, Atlanta, Ga. (Emory U. 1954)  
 Mixson, Charles Andrew, Birmingham, Ala. (Med. Coll. Alabama 1958)  
 Mladick, Richard Anthony, Chicago (Northwestern U. 1959)  
 Montgomery, James Augustin, Jacksonville (Tulane U. 1958)  
 Moore, Gene, Bartow (Vanderbilt U. 1954)  
 Moore, Irwin Bernard, Durham, N. C. (Duke U. 1958)  
 Moore, Marcus McDuffie, Durham, N. C. (Duke U. 1959)  
 Moore, Richard Ben, Indianapolis (Indiana U. 1952)  
 Moorhead, Frank Albert, Lutz (U. Miami 1959)  
 Morris, John William III, Atlanta, Ga. (Emory U. 1959)  
 Moseley, Dayton Lee Jr., New Orleans (Louisiana St. U. 1943)  
 Moseley, James Edward, Raiford (U. Tenn. 1950)  
 Murguia, Lorenzo, Key West (U. Miami 1959)  
 Murphree, Henry Bernard Scott, Miami (Emory U. 1959)  
 Mutter, Charles Bernard, Miami Beach (U. Miami 1959)  
 Naness, Sidney, Miami Beach (U. Miami 1959)  
 Neuwirth, Robert Samuel, New York (Yale U. 1958)  
 Nevyas, Herbert Julian, Philadelphia (U. Penn. 1959)  
 Nicholson, Charles Preston Jr., Atlanta, Ga. (U. Tenn. 1958)  
 Norton, Barry Parker, Durham, N. C. (Duke U. 1959)  
 Olsen, Julian Ole Jr., Mobile, Ala. (Tulane U. 1958)  
 Olsen, Oluf Edwin, Maitland (Coll. Med. Evang. 1958)  
 Peagler, Charles Gerald, Baltimore (M.C. Ga. 1952)  
 Perdomo, Octavio Jorge, Miami (U. Havana 1938)  
 Pickett, Wilbur Crafts Jr., Gainesville (U. Maryland 1956)  
 Pierson, Henry Earl Jr., Chipley (U. Tenn. 1959)  
 Poole, Catherine Ann, Coral Gables (U. Oregon 1958)  
 Popovich, Paul John, Great Falls, Mont. (St. Louis U. 1951)  
 Purcell, Jack Henry, St. Petersburg (Indiana U. 1947)  
 Rapaport, Stanley Leon, Fern Park (U. So. Calif. 1955)  
 Rapperport, Alan Sherwin, Miami (Tulane U. 1959)  
 Rauschenberger, David Schenck, Orlando (U. Pittsburgh 1958)  
 Ray, Larry Graydon, Decatur, Ga. (Emory U. 1959)  
 Raymond, George David, Chapel Hill, N. C. (Harvard 1959)  
 Raymond, Harry Paul Jr., Vandenberg AFB, Calif. (Johns Hopkins U. 1950)  
 Raymond, Thomas Francis, Daytona Beach (U. Penn. 1959)  
 Renfro, Samuel Leon, Jacksonville (Vanderbilt U. 1959)  
 Richards, George Llewellyn, Miami (Temple U. 1952)  
 Richardson, John Robert Jr., Miami (Emory U. 1954)  
 Rivera Trujillo, Antonio, Lake City (Georgetown U. 1950)  
 Roggenkamp, Milton Warren, Bradenton (Indiana U. 1952)  
 Rosenthal, Jerome, Brooklyn (Harvard 1959)  
 Roth, Abraham David, Miami (Johns Hopkins U. 1957)  
 Ruffin, William Cain Jr., Gainesville (U. No. Carolina 1955)  
 Sack, Josua, Coral Gables (U. Leiden 1956)  
 Sacrinty, Nicholas William, Jacksonville (Bowman Gray 1952)  
 Sagerman, Robert Howard, Rome, N. Y. (N. Y. U. 1955)  
 Salitsky, Sherwood Norman, Camden, N. J. (Hahnemann 1957)  
 Sandberg, Douglas Herbert, Coral Gables (Bowman Gray 1955)  
 Sanders, Marilyn Miller, Miami (U. Louisville 1958)  
 Schalk, Herman Albert, St. Louis (Indiana U. 1957)  
 Schroeder, Henry Fred, Miami (New York M. C. 1958)  
 Schwimmer, Walter Barton, Brooklyn, (N.Y.U.-Bellevue 1959)  
 Scott, Thomas Irving, Columbus, Ga. (Emory U. 1959)  
 Seidell, Martin Ambrose, Orlando (Indiana U. 1946)  
 Serros, Robert Nicholas, New Orleans (U. Miami 1959)  
 (Continued on page 494)



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they deserve

# GEVRAL<sup>®</sup>

Vitamin-Mineral Supplement **Lederle**

**CAPSULES—14 VITAMINS—11 MINERALS**

LEDERLE LABORATORIES, a Division of  
 AMERICAN CYANAMID COMPANY, Pearl River, New York





# Now — All cold symptoms can be controlled



## Tussagesic

*timed-release tablets*

### *Controls congestion*

with Triaminic,<sup>1,2,3</sup> the leading oral nasal decongestant.

### *Controls aches and fever*

with well-tolerated APAP, non-addictive analgesic<sup>4</sup> and excellent antipyretic.<sup>5</sup>

#### *Each TUSSAGESIC Tablet provides:*

TRIAMINIC® ..... 50 mg.  
(phenylpropanolamine HCl ..... 25 mg.  
pheniramine maleate ..... 12.5 mg.  
pyrilamine maleate ..... 12.5 mg.)

Dormethan  
(brand of dextromethorphan HBr) ..... 30 mg.  
Terpin hydrate ..... 180 mg.  
APAP (N-acetyl-p-aminophenol) ..... 325 mg.

*References:* 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p. 78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 547.

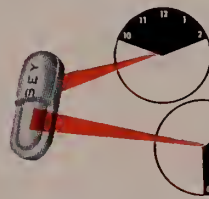
### *Controls cough centrally*

with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,<sup>6</sup> as effective as codeine.

### *Liquefies tenacious mucus*

with terpin hydrate, classic expectorant.

*Prompt and prolonged relief because of this special "timed release" design:*



*first — the outer layer dissolves within minutes to give 3 to 4 hours of relief*

*then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours*

*Dosage:* One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

**TUSSAGESIC SUSPENSION** provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

**SMITH-DORSEY** • a division of The Wander Company • Lincoln, Nebraska

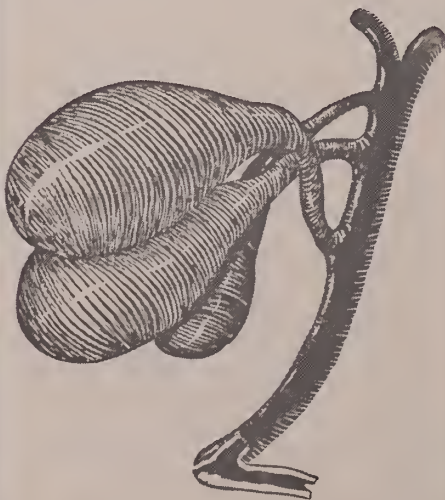
# AN AMES CLINIQUICK<sup>TM</sup>

CLINICAL BRIEFS FOR MODERN PRACTICE

## HOW PREVALENT ARE MULTIPLE GALLBLADDER ANOMALIES?

One hundred and twenty-two cases of *vesica fellea divisa* (bilobed gallbladder) and *vesica fellea duplex* (double gallbladder with 2 cystic ducts) are reported in the literature. A unique case of *vesica fellea triplex* has recently been described.

Source: Skilboe, B.: Am. J. Clin. Path. 30:252, 1958.



in medical  
management  
and postoperative  
care of biliary  
disorders...

"effective" hydrocholeresis...

## DECHOLIN<sup>®</sup>

(dehydrocholic acid, AMES)

"...dehydrocholic acid...does considerably increase the volume output of a bile of relatively high water content and low viscosity. This drug is therefore a good 'flusher,' and is effectively used in treating both the chronic unoperated patient and the patient who has a T-tube drainage of an infected common bile duct."<sup>1</sup>

*free-flowing bile*

*plus reliable spasmolysis*

## DECHOLIN<sup>®</sup> WITH BELLADONNA

"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."<sup>2</sup>

- (1) Beckman, H.: *Drugs: Their Nature, Action and Use*, Philadelphia, W. B. Saunders Company, 1958, p. 425.  
(2) *Biliary Tract Diseases*, M. Times 85:1081, 1957.

**AMES**  
COMPANY, INC.  
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# Synonyms for Pain Relief...

'TABLOID'

## 'EMPIRIN' COMPOUND®

Acetophenetidin . . . . . gr. 2½  
Acetylsalicylic Acid . . . . gr. 3½  
Caffeine . . . . . gr. ½

'TABLOID'

## 'EMPIRIN' COMPOUND®

WITH

## CODEINE PHOSPHATE\*

No. 1

Acetophenetidin . . . . . gr. 2½  
Acetylsalicylic Acid . . . . gr. 3½  
Caffeine . . . . . gr. ½  
Codeine Phosphate . . . . gr. ⅛

No. 2

Acetophenetidin . . . . . gr. 2½  
Acetylsalicylic Acid . . . . gr. 3½  
Caffeine . . . . . gr. ½  
Codeine Phosphate . . . . gr. ¼

No. 3

Acetophenetidin . . . . . gr. 2½  
Acetylsalicylic Acid . . . . gr. 3½  
Caffeine . . . . . gr. ½  
Codeine Phosphate . . . . gr. ½

No. 4

Acetophenetidin . . . . . gr. 2½  
Acetylsalicylic Acid . . . . gr. 3½  
Caffeine . . . . . gr. ½  
Codeine Phosphate . . . . gr. 1

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...providing the desired  
gradation of potencies  
for relief of varying  
intensities of pain

IN

simple headache  
rheumatic conditions  
arthralgias  
myalgias  
common cold  
toothache  
earache  
dysmenorrhea  
neuralgia  
minor trauma  
tension headache  
premenstrual tension  
minor surgery  
post-partum pain  
trauma  
organic disease  
neoplasm  
muscle spasm  
colic  
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musculo-skeletal pains  
postdental surgery  
post-partum involution  
fractures  
synovitis/bursitis

relief of pain  
of all degrees of  
severity up to  
that which  
requires morphine

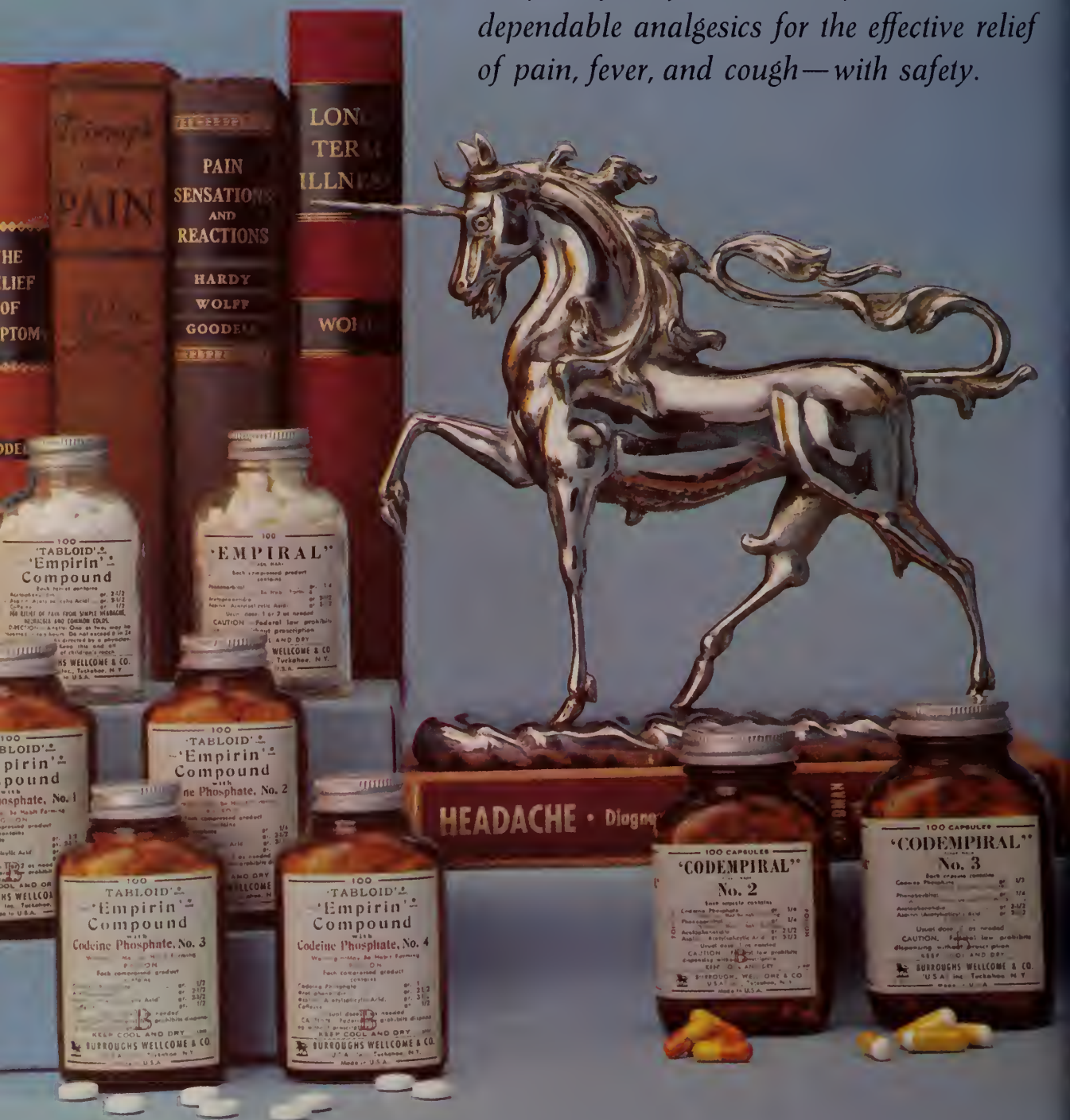
AND IN

fevers  
dry,  
unproductive coughs





*Your experience and trust throughout the years have established the wide use of the 'Empirin' family in medical practice—dependable analgesics for the effective relief of pain, fever, and cough—with safety.*



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## CONVENIENCE and ECONOMY

*for that all-important first dose  
of broad-spectrum antibiotic therapy*

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**TERRAMYCIN<sup>®</sup>**

brand of oxytetracycline

## INTRAMUSCULAR SOLUTION

Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

*...and for continued, compatible,  
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## COSA-TERRAMYCIN<sup>®</sup> CAPSULES

oxytetracycline with glucosamine

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

*Supply:*

*Terramycin Intramuscular Solution\**

100 mg./2 cc. ampules

250 mg./2 cc. ampules

*Cosa-Terramycin Capsules*

125 mg. and 250 mg.

*Cosa-Terramycin is also available as:*

*Cosa-Terramycin Oral Suspension* — peach flavored,  
125 mg./5 cc., 2 oz. bottle

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5 mg./drop (100 mg./cc.), 10 cc. bottle  
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Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

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# avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4,5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2,4,5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

**CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage**



Regular aspirin crystals 24 hours after being mixed into water.

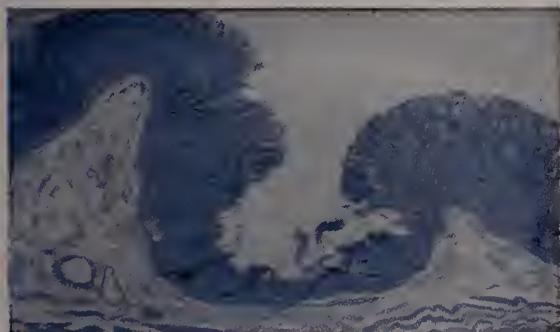


Calurin crystals in solution one minute after being mixed into water.

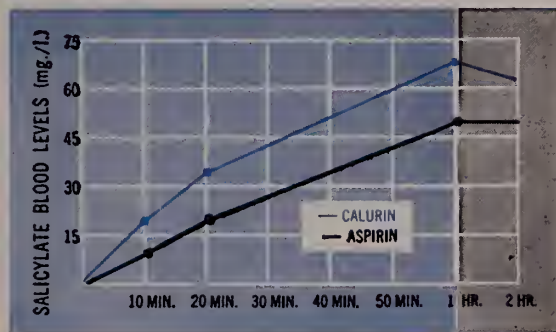


# CALURIN\*

STABLE SOLUBLE CALCIUM-ACETYSALICYLATE-CARBAMIDE



**Particle-induced ulceration** — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

\*TRADE MARK

*(Continued from page 488)*

- Shane, Ronald William, Miami Beach (Temple U. 1958)  
 Shaver, Edward Franklin Jr., Bonifay (Tulane U. 1959)  
 Sigel, Bernard, Miami (U. Texas 1953)  
 Sincox, Francis John Jr., Valley Stream, N. Y. (Emory U. 1958)  
 Smith, Charles Frank Jr., New Orleans (Tulane U. 1959)  
 Smith, Oren Rudolph Jr., Jacksonville (Tulane U. 1959)  
 Smith, Tim Murphy, Savannah, Ga. (U. Miami 1959)  
 Solomon, James Wolfe, Miami (U. Miami 1959)  
 Stambaugh, Reginald Jack, West Palm Beach (U. Miami 1959)  
 Stathis, Anthony Lucido, Miami Springs (U. Miami 1959)  
 Stemle, Duane Leo, Indianapolis (Indiana U. 1958)  
 Stoneburner, John Moore, Richmond, Va. (M. C. Virginia 1950)  
 Tarr, Eric Gordon, St. Petersburg (Coll. Med. Evang. 1958)  
 Taul, Esrael Jay, Miami Beach (Louisiana St. U. 1958)  
 Tausend, Stanleigh Sydney, New York (U. Cinn. 1925)  
 Taylor, Thomas Lee, Jacksonville (Cornell 1953)  
 Thomas, Martin Alfred, Tampa (Indiana U. 1952)  
 Tienstra, Joseph Edward, Lake City (U. Illinois 1954)  
 Tindall, John Philip, Kissimmee (Duke U. 1959)  
 Tobin, Wayne Ernest, Miami Beach (Tulane U. 1959)  
 Tolbert, Robert Daniel, Tampa (Indiana U. 1958)  
 Touger, Norman, Bronx, N. Y. (U. Geneva 1956)  
 Townsend, James Joye, Jacksonville (Duke U. 1956)  
 Trimby, Robert Hosea, Fort Lauderdale (U. Michigan 1940)  
 Truly, Harry Lydmore Jr., Orlando (Tulane U. 1949)  
 Tweed, Clyde Gilbert, Gainesville (Duke U. 1958)  
 Vaile, Victor Edward III, Galveston, Tex. (Ohio St. U. 1959)  
 Van Cleve, Robert Baldwin, Jacksonville (Columbia U. 1958)  
 Verner, John Victor Jr., Durham, N. C. (Duke U. 1954)  
 Villoch, Claudio Rapado, Miami (U. Havana 1953)  
 Vinson, Robert Harrell, Gainesville (U. No. Carolina 1954)  
 Vinton, Richard Allen Jr., Venice (U. Virginia 1955)  
 Wachal, John Henry, Englewood (U. Nebraska 1958)  
 Wallace, William Davies Jr., Washington, D.C. (Jefferson 1953)  
 Walter, Eugene Paul, Warrington (Tulane U. 1958)  
 Wasselle, Gerard William Andrew, Bethesda, Md. (U. Miami 1959)  
 Watt, Russell Hyde, Marshalltown, Ia. (Northwestern U. 1959)  
 Watts, Jerald Lee, Atlanta, Ga. (Emory U. 1959)  
 Webster, George Davis Jr., Miami (Western Reserve U. 1948)  
 Weiffenbach, Eugene Jon, Clearwater (Tulane U. 1959)  
 Weinstein, Philip Jr., Miami (Washington U. 1956)  
 Weir, Robin Slane, Delray Beach (U. Miami 1958)  
 Weybright, Dorthea Margaret, Detroit (U. Oregon 1951)  
 Wheat, Myron William Jr., Gainesville (Washington U. 1951)  
 White, Hayes MacMurry Jr., Asheboro, N. C. (Duke U. 1945)  
 White, Henry Chandler Jr., Augusta, Ga. (M. C. Georgia 1959)  
 Whitehurst, James Ray, West Palm Beach (U. Miami 1959)  
 Whitney, Randall Brooks, Jacksonville (Tulane U. 1959)  
 Wilhelm, Daniel Arthur, Miami (U. Miami 1959)  
 Williams, Claude McKnight, Memphis, Tenn. (U. Tenn. 1949)  
 Williams, Jay Dayton Jr., Atlanta, Ga. (Emory U. 1959)  
 Williams, John L. Jr., Decatur, Ga. (Emory U. 1959)  
 Williams, Robert Leon, Gainesville (Albany M. C. 1946)  
 Wilson, Creighton Lemaster, Miami (U. Tenn. 1954)  
 Wilson, Ohlen Rudolph, Alma, Ga. (M. C. Virginia 1954)  
 Witus, Warren Saul, Surfside (U. Michigan 1952)  
 Wolf, Sheldon Mark, New York (Columbia U. 1959)  
 Wolff, Floyd, Hollywood (Northwestern U. 1959)  
 Wollin, Ernest, Miami (Northwestern U. 1958)  
 Wood, Roy Stanley, Durham, N. C. (Duke U. 1958)  
 Wynn, Mark Francis, Miami (U. Miami 1959)

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*“Good for you!”*

BEAUTIFUL JUMP! And you made it look so very easy. Good time now to rest . . . relax . . . toast the moment with a good glass of beer. Nothing, you know, is so rewarding. Beer's bright, light—refreshing. And no other beverage is so right on so many different occasions. It really picks you up, too.

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Beer's rich in wonderful, healthful things. Nature's own choice barley malt, hops, minerals, and the purest water. Good wholesome beer or ale perks you up—won't let you down.



Youmans, Comer Roger Jr., Atlanta, Ga. (Emory U. 1959)  
 Youmans, Paul Lee, North Augusta, S. C. (M. C. Georgia 1958)  
 Zane, Sheldon, Miami (U. Miami 1959)  
 Zelickson, Alvin Sheldon, Minneapolis (U. Minn. 1955)  
 Zippert, George John, Oneida, N. Y. (Hamburg U. 1934)

## BIRTHS AND DEATHS

### Marriages

Dr. Fred Mathers of Orlando and Miss Mary Parker McCraw of Orlando were married there August 14, 1959.

Dr. Elmer H. Gillespie of Clearwater and Mrs. Patricia M. Branch of Clearwater were married there June 13, 1959.

### Deaths — Members

Darrow, Anna A., Coral Gables..... July 22, 1959  
 Ferlita, Americo J., Tampa..... July 2, 1959  
 Kass, Paul N., North Miami..... May 26, 1959  
 Norman, Estella G., Davis City, Iowa..... July 28, 1959  
 Rowntree, Leonard G., Miami Beach..... June 2, 1959

### Deaths — Other Doctors

Adams, Charles C., Atlanta, Ga..... April 17, 1959  
 Braunlin, Carl Gustave, Portsmouth, Ohio..... July 9, 1959  
 Dixon, William H.,  
     Rocky Mount, N. C..... January 1, 1959  
 Howard, Frank Davis, Leesburg..... May 27, 1959  
 Sayre, Bernard Edward, Chicago, Ill..... March 30, 1959  
 Powers, Earl J.,  
     Winston-Salem, N. C..... September 21, 1958  
 Thornbury, Richard Henry,  
     North Collins, N. Y..... January 7, 1959  
 Wright, Victor H., Ocala..... January 18, 1959

## NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, Hildreth V. II, Mascot, Tenn.  
 Belding, Warren L., Orlando  
 Benet, Armando F., Tampa  
 Corey, Arthur E., Orlando  
 Craig, Louis C., Pompano Beach  
 Damron, John R., Ft. Lauderdale  
 Dever, Richard C., Miami  
 Haley, Raymond C. Jr., Ormond By The Sea  
 Haynes, William N., Coral Gables  
 Hudgens, John C. Jr., Orlando  
 Kaiser, Herbert S., Miami  
 Liechty, John D., Ft. Lauderdale  
 Mann, Richard M., Miami Beach  
 Morgan, Leslie A., Orlando  
 Moses, Robert J. Jr., Hialeah  
 Murphy, Ray E. Jr., Pompano Beach  
 Offen, Joseph A., Coral Gables  
 Prout, George R. Jr., Miami  
 Strasser, Hans A., Kissimmee

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Each capsule contains:

Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B <sub>12</sub> with AUTRINIC <sup>®</sup>	
Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B <sub>1</sub> )	5 mg.
Riboflavin (B <sub>2</sub> )	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B <sub>6</sub> )	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
L-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as CaHPO <sub>4</sub> )	157 mg.
Phosphorus (as CaHPO <sub>4</sub> )	122 mg.
Boron (as Na <sub>2</sub> B <sub>4</sub> O <sub>7</sub> · 10H <sub>2</sub> O)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF <sub>2</sub> )	0.1 mg.
Manganese (as MnO <sub>2</sub> )	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K <sub>2</sub> SO <sub>4</sub> )	5 mg.
Zinc (as ZnO)	0.5 mg.



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

# RECTALAD<sup>®</sup> MINIATURE ENEMA

IN RECTALAD  
DISPOSABLE  
DISPENSER

## NEWEST

"in most cases  
preferable  
to large enemas"<sup>1</sup>

## SMALLEST

"more convenient . . .  
and more effective  
than the suppository"<sup>1</sup>



### ALLAYS FEAR AND DISCOMFORT OF CONVENTIONAL ENEMAS AND LARGE-VOLUME DISPOSABLE ENEMAS

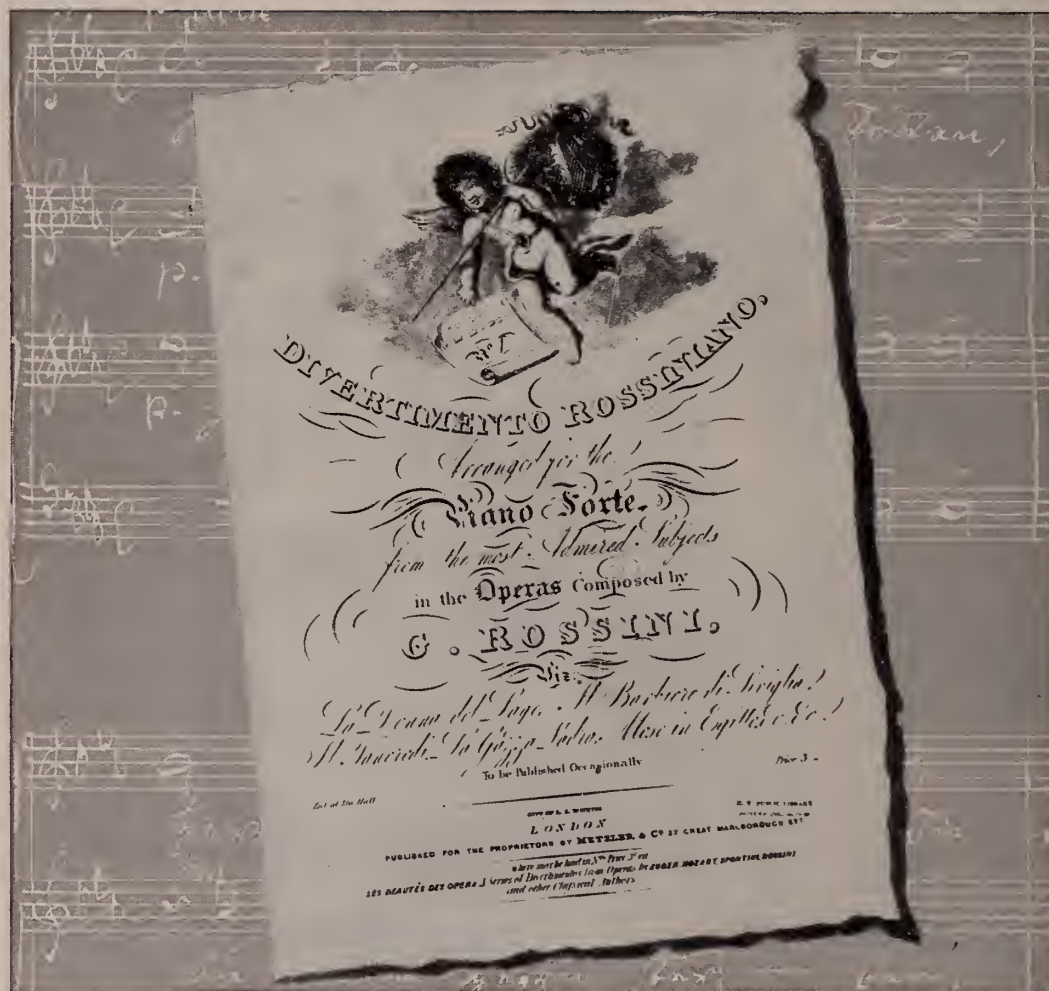
Topical action triggers the defecatory reflex to produce natural peristalsis in the lower bowel only. Wetting agent spreads ingredients to lubricate and soften the fecal mass for easier passage. Results are rapid<sup>2</sup> and, in over 90% of patients, completely satisfactory.<sup>1,3</sup> Economical RECTALAD MINIATURE ENEMA is not absorbed, does not disturb fluid-electrolyte balance and is well tolerated by patients of all ages.

RECTALAD<sup>®</sup> MINIATURE ENEMA contains glycerin, sodium stearate, dioctyl sodium sulfosuccinate and water in a self-contained disposable unit. For your prescription or recommendation: 5 cc. adult size and 2 cc. pediatric size. Samples available on request.

*References:* 1. Aries, P. L.: J.A.M.A. 169:708 (Feb. 14) 1959. 2. Personal Communication on file at Medical Department, Wampole Laboratories. 3. Reports of clinical trials by 9 physicians.

WAMPOLE LABORATORIES, STAMFORD, CONN.





The great operatic works of Rossini have  
been enjoyed by millions for many decades

## THINGS THAT ENDURE

Good things endure... a work of art,  
a literary classic, a proud bridge... a dependable  
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35 years Desitin Ointment has endured as an incom-  
parable, safe way to prevent and clear up diaper rash  
...and as a soothing, healing application in wounds,  
burns, external ulcers and other skin injuries.

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More effective than salicylate alone  
in antirheumatic therapy . . .

# Pabalate®



COMBINING MUTUALLY SYNERGISTIC NON-STEROID ANTIRHEUMATICS

"superior to aspirin" — "...evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."<sup>1</sup>

In each enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.).....	0.3 Gm.
Sodium para-aminobenzoate (5 gr.)..	0.3 Gm.
Ascorbic acid .....	50.0 mg.

Robins

For the patient  
who requires steroids

## Pabalate-HC®

Pabalate with Hydrocortisone

For the patient  
who should avoid sodium

## Pabalate®-Sodium Free

Same formula as Pabalate, with sodium  
salts replaced by potassium salts

In each enteric-coated PABALATE-HC tablet:  
Hydrocortisone ..... 2.5  
Potassium salicylate (5 gr.)..... 0.3  
Potassium para-aminobenzoate (5 gr.).. 0.3  
Ascorbic acid ..... 50.0

1. Ford, R. A., and Blanchard.  
Journal-Lancet 78:185, 1955

A. H. ROBINS CO., INC., Richmond 20, Virginia

Ethical Pharmaceuticals of Merit since 1844

# "a highly effective antitussive"<sup>1</sup>

*Preferred by patients as to "effectiveness, taste  
and absence of undesirable side-effects"<sup>2</sup>*

**Robitussin:** Each 5-cc. tea-  
spoonful contains glyceryl  
guaiacolate 100 mg.

**Robitussin A-C:** Same formula,  
plus prophenpyridamine  
maleate 7.5 mg. and codeine  
phosphate 10 mg. per 5 cc.  
Exempt narcotic.

**Supply:** Bottles of 4 fl. oz.,  
1 pint and 1 gallon.

1. Bickerman, H. A.: *In Drugs of  
Choice 1958-1959*, ed. by W. Modell,  
Mosby, St. Louis, 1958, p. 562.

2. Hayes, E. W., and Jacobs, L. S.:  
*Dis. Chest* 30:441, 1956.

A. H. **Robins** CO., INC., RICHMOND 20, VIRGINIA  
*Ethical Pharmaceuticals of Merit since 1878*

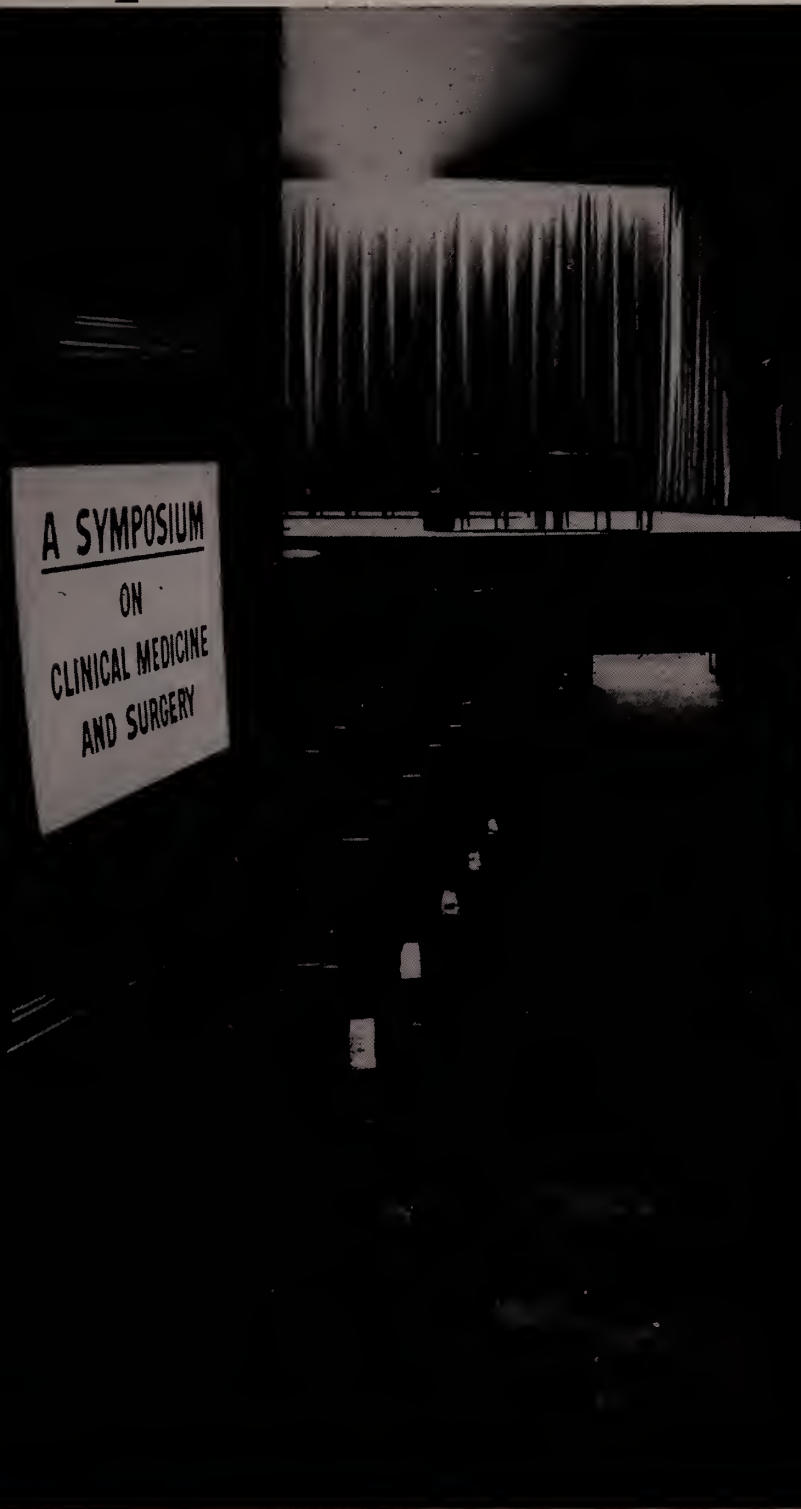
# Robitussin<sup>®</sup> or Robitussin<sup>®</sup> A-C



ROBITUSSIN WITH ANTIHISTAMINE AND CODEINE



# Open To All Physicians . . .



## 1959 Symposia

### OKLAHOMA CITY, OKLAHOMA

Fri., Oct. 2, 1959, The Skirvin Hotel

### BIRMINGHAM, ALABAMA

Sun., Oct. 11, 1959, The Dinkler-Tutwiler Hotel

### TACOMA, WASHINGTON

Wed., Oct. 14, 1959, The Hotel Winthrop

### TRAVERSE CITY, MICHIGAN

Fri., Oct. 23, 1959, The Park Place Hotel

### LUBBOCK, TEXAS

Sat., Oct. 31, 1959, The Lubbock Country Club

### ST. CHARLES, ILLINOIS

Wed., Nov. 4, 1959, The St. Charles Country Club

### DALLAS, TEXAS

Fri., Nov. 6, 1959, The Hilton Hotel

### WICHITA, KANSAS

Sat., Nov. 7, 1959, The Hotel Broadview

### SCHENECTADY, NEW YORK

Thurs., Nov. 12, 1959, The Mohawk Golf Club

### CORPUS CHRISTI, TEXAS

Fri., Nov. 13, 1959, The Robert Driscoll Hotel

### RIVERSIDE, CALIFORNIA

Sun., Nov. 15, 1959, The Mission Inn

### SANTA BARBARA, CALIFORNIA

Wed., Nov. 18, 1959, The Santa Barbara Biltmore

### MOLINE, ILLINOIS

Wed., Dec. 2, 1959, The LeClaire Hotel

## 1960 Symposia (incomplete schedule)

### DENVER, COLORADO

Sun., Jan. 10, 1960, The Cosmopolitan Hotel

### AUSTIN, TEXAS

Fri., Jan. 15, 1960, The Commodore Perry

### POCATELLO, IDAHO

Sat., April 2, 1960, The Bannock Hotel

### MOORHEAD, MINNESOTA

Sat., April 9, 1960, The Frederick Martin Hotel

### SALT LAKE CITY, UTAH

Fri., April 22, 1960, Hotel Utah

### ST. LOUIS, MISSOURI

Sun., May 1, 1960, Chase-Park Plaza

### SANTA ROSA, CALIFORNIA

Fri., Sept. 16, 1960, The Flamingo Hotel

### GREAT FALLS, MONTANA

Sat., Oct. 22, 1960, The Rainbow Hotel

### CHARLESTON, WEST VIRGINIA

Sun., Oct. 30, 1960, The Daniel Boone Hotel

In cooperation with medical organizations throughout the United States, Lederle continues to offer aid to post-graduate medical education through its Symposium program. Upon completion of the schedule above the number of Symposia presented will exceed 200 since the first meeting, sponsored by the Knoxville (Tenn.) Academy of Medicine eight years ago. Each meeting presents prominent authorities discussing important advances in clinical medicine and surgery. Activities are also planned for physicians' wives.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York 



*Can antacid therapy  
be made more effective  
and more pleasant*



THE MOST SIGNIFICANT IMPROVEMENT IN  
ANTACID THERAPY SINCE THE INTRODUCTION  
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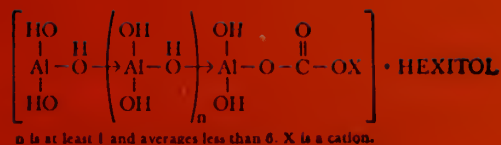
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Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, (stabilized with hexitol), with 75 mg. magnesium hydroxide.

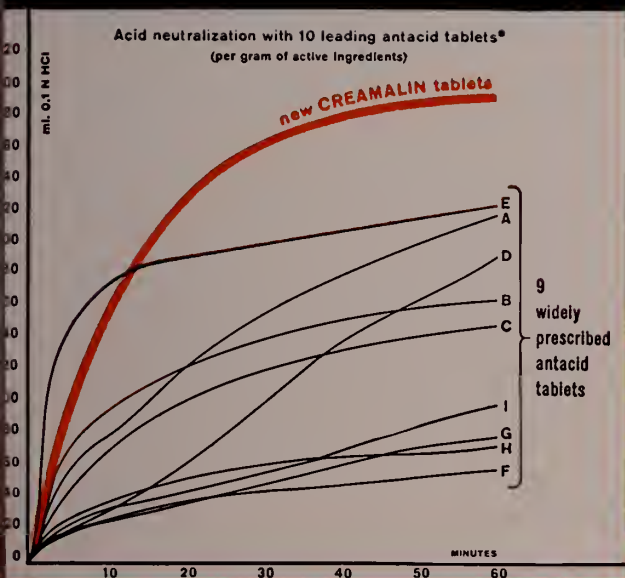
- 1. Neutralizes acid faster (quicker relief)*
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- 4. No constipation • No acid rebound*
- 5. More pleasant to take*

a new high in effectiveness  
and palatability



## CREAMALIN NEUTRALIZES MORE ACID FASTER

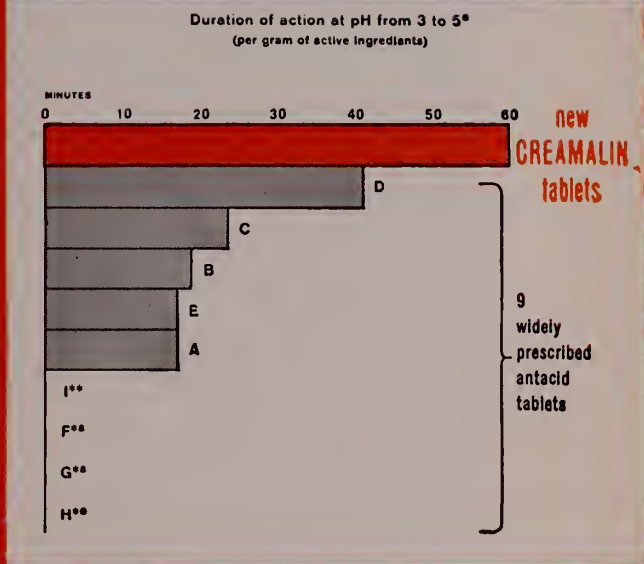
Quicker Relief • Greater Relief



\*Tablets tested: A. T. T. (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); B. Alka-Seltzer (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); C. Alka-Mints (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); D. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); E. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); F. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); G. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); H. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); I. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); J. Alka-Prep (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland).

## CREAMALIN NEUTRALIZES MORE ACID LONGER

More Lasting Relief



\*pH 3 to 5. T. T. (F. Hoffmann-La Roche & Co., Ltd., Basel, Switzerland); M. L. A new highly reactive aluminum hydroxide compound for gastric hyperacidity. To be published.

\*\*pH stayed below 3.

Do antacids have to taste  
like chalk?



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

- NO ACID REBOUND • NO CONSTIPATION
- NO SYSTEMIC EFFECT

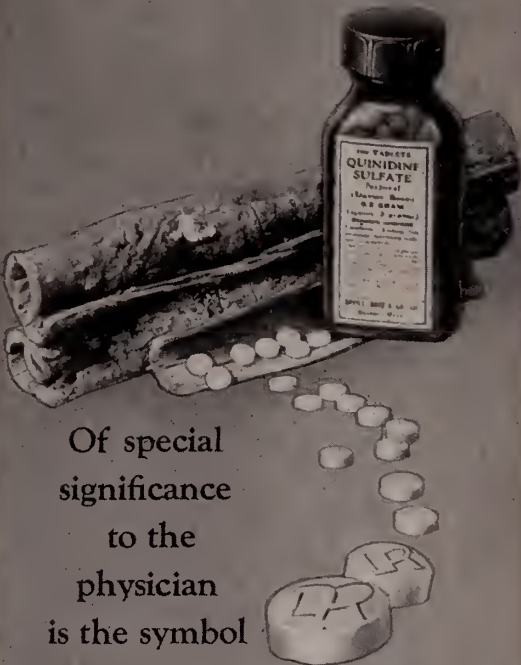
**Adult Dosage:** Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

**Supplied:** Bottles of 50, 100, 200 and 1000.

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When he sees it engraved  
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## The distinctive PREMIERE suite By *Hamilton*



Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere — and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basin and pull-out step are included.

Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can be used separately as a wall cabinet and the lower section as a treatment stand. This option allows a greater variety of room arrangement according to personal preference and requirements.

See the new Premiere and other Hamilton suites in wood and steel now.



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# CHOICE THERAPY FOR THE "OLDER" PATIENT WITH MILD TO MODERATE HYPERTENSION



## R<sub>x</sub> Veratrite®

More than 13,000,000 prescriptions attest that Veratrite continues to be the antihypertensive of choice for the older hypertensive patient. Veratrite can be prescribed safely and routinely for those who usually cannot tolerate more potent drugs.

Veratrite now contains cryptenamine which acts centrally to produce a gradual fall in blood pressure, yet improves circulation to vital organs, relieves dizziness and headache, and imparts a distinct sense of well-being. Furthermore, Veratrite achieves its effects with unusual safety and without annoying side effects.

Each Veratrite tabule contains: Cryptenamine (tanates), 40 C.S.R.\* Units; Sodium nitrite, 1 gr.; Phenobarbital,  $\frac{1}{4}$  gr. Dosage: 1-2 tabules t.i.d., preferably 2 hours after meals.

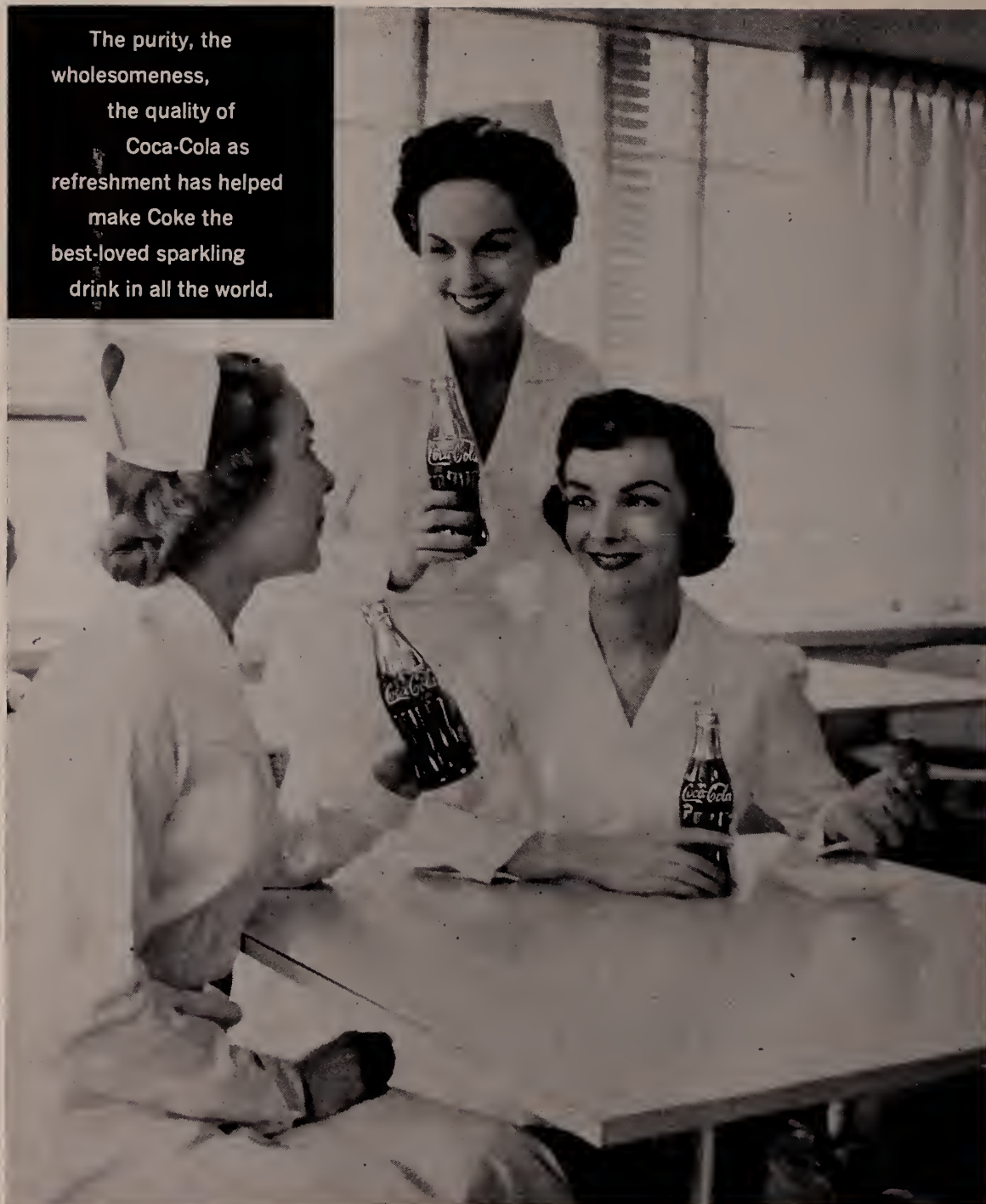
\*Carotid Sinus Reflex



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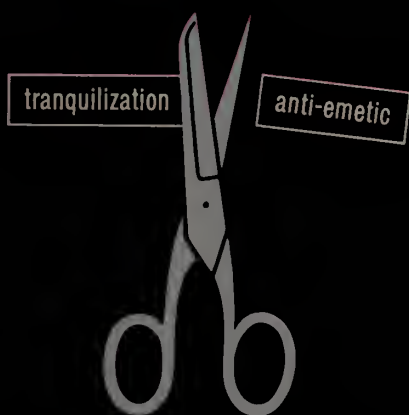
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wholesomeness,  
the quality of  
Coca-Cola as  
refreshment has helped  
make Coke the  
best-loved sparkling  
drink in all the world.



SIGN OF GOOD TASTE



# now potent tranquilizer therapy is safer than ever



*Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.*

MELLARIL is virtually free  
of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>1</sup>



**Mellaril<sup>®</sup>**  
THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

## remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis—even when given in quantities far in excess of the usual dosage.

### "POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects....In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."<sup>2</sup>

### NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent....Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."<sup>3</sup>

### SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in

any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."<sup>4</sup>

### ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."<sup>1</sup>

### MINIMAL SIDE EFFECTS

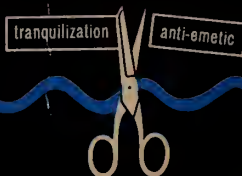
"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."<sup>5</sup>

### NO JAUNDICE

"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."<sup>6</sup>

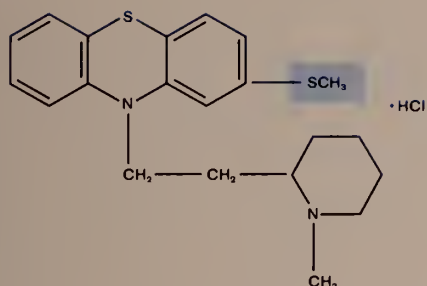
**Mellaril**<sup>®</sup>  
THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels





a new advance in tranquilization:  
greater specificity of tranquilizing action plus fewer side effects



*Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical ( $\text{S-CH}_3$ ) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

**MELLARIL**

PSYCHIC RELAXATION

DAMPENING OF  
SYMPATHETIC AND  
PARASYMPATHETIC  
NERVOUS SYSTEM

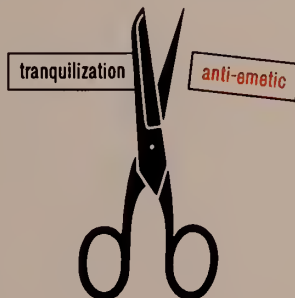
Minimal suppression of vomiting  
Little effect on blood pressure  
and temperature regulation

Psychic relaxation

Dampening of  
sympathetic and  
parasympathetic  
nervous system

Strong suppression of vomiting  
Dampening of blood pressure  
and temperature regulation

**other  
phenothiazine-type  
tranquilizers**

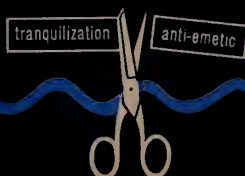


- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.
- 5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

**Mellaril®**  
THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



# a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely dis-

turbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

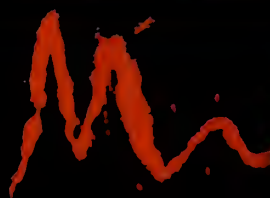
**PRECAUTIONS:** Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In

particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

**SUPPLIED:** MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

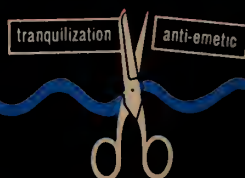
1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. 115:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. 88:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959.

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels



Mellaril<sup>®</sup>  
THIORIDAZINE HCl

specific, effective tranquillizer • safer at all dosage levels





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## in Geriatrics and the treatment of the Anorexic, Debilitated Patient....

*From time immemorial physicians have been aware of the restorative powers of wine.*

### *A Tasty Aid to Appetite and Digestion*

A glass of Sherry at mealtime stimulates the jaded appetite, serves as a tonic and aids the digestion. As a postprandial or between-meals' beverage, a glass of Port has been warmly recommended for the sick and enfeebled.

Wine has been found to increase salivary flow and stimulate gastric secretion.

### *A Nutrient in Itself*

The ease with which wine is metabolized makes it an important nutritive factor.

### *A Gentle Vasodilator and Sedative*

The systemic sedative and vasodilative actions of wine can be of great aid and comfort to both the aged and the convalescent, particularly in the presence of cardiovascular disease.

These and other therapeutic uses of wine are discussed in the physician's brochure, "Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.







Convalescence



Adolescence



Infant diarrhea

Debilitating  
gastrointestinal  
conditions

Postoperatively

Whenever  
the diet is faulty,  
the appetite poor,  
or the loss of food  
is excessive

*through vomiting  
or diarrhea—*

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stimulates the appetite,  
increases the flow of  
digestive juices,

provides: supplementary  
amounts of vitamins, minerals  
and soluble proteins,

extra-dietary vitamin B<sub>12</sub>,

protective quantities of  
potassium, in a palatable and  
readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE is 1 teaspoonful two or three times  
daily; two or three times this amount for  
potassium therapy.

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### Looking Ahead

During these past three summer months, the officers of the Woman's Auxiliary to the Florida Medical Association have been "looking ahead" and making plans for the coming year. We hope that we will be able to serve the Florida Medical Association in every way possible; the only purpose of our existence is to carry out your instructions to us. This we will do.

As President of the Auxiliary I have recently attended the meeting of the Woman's Auxiliary to the American Medical Association. At these meetings the states are urged to bring ideas and problems and one soon learns what other states are doing in various phases of auxiliary endeavor. It may please you to know that Florida won first place in the Today's Health contest for auxiliaries of its size—certainly the combined efforts of all the counties working to support what you had asked us to do.

Our quota for AMEF was met. This, too, is something you had asked us to do. I sincerely hope you do not think we are an over-organized group of women "chasing goat feathers." We like to think we are here to help and we want to do the best possible job.



Have you ever thought of the fact that the nurse you now employ might have become interested in nursing through the Future Nurses Clubs sponsored by the medical auxiliaries throughout the state? Working with these possible Future Nurses can be most rewarding. Perhaps your wife would volunteer a little more time to this project if she knew you really appreciated having more girls enter this vocation.

We are most interested in the field of public safety. Did you know that some of your wives manned booths at various fairs in order to distribute literature on the poison centers set up around the state? Is there something more we can do for you in the field of public safety?

I could go on in many other fields in which you have asked our help—legislation, mental health and civil defense. We are trying to do our

(Continued on page 520)



running noses    
and open stuffed noses orally

# Triaminic<sup>®</sup>

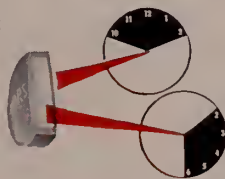
*the leading oral nasal decongestant*

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

*safer and more effective than topical medication<sup>1,2,3</sup>*

- systemic transport to all respiratory membranes
- provides longer-lasting relief
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- avoids "nose drop addiction"

*Relief with Triaminic is prompt  
and prolonged because of this  
special timed-release action ...  
beneficial effect starts in  
minutes, lasts for hours*



*first*—the outer layer  
dissolves within minutes  
to produce 3 to 4 hours  
of relief

*then*—the core disintegrates  
to give 3 to 4 more hours  
of relief

*Each TRIAMINIC Tablet provides:*

Phenylpropanolamine HCl .....50 mg.  
Pheniramine maleate .....25 mg.  
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

*Dosage:* One tablet in the morning, mid-afternoon and at bedtime.

*References:* 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

**TRIAMINIC JUVELETS:** Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

**TRIAMINIC SYRUP** is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to  $\frac{1}{4}$  of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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# MICRONITE FILTER:

## key to Kent's popularity

During the past year, Kent sales increased by 20-billion cigarettes—the greatest gain in popularity ever recorded by any filter cigarette in any year.

Undoubtedly much of the credit for this important rise in sales must go to Kent's exclusive "MICRONITE" Filter. This extraordinary new filter was constructed to take into account new principles of filtration which were dictated by the basic discoveries of a major research foundation, working under Lorillard sponsorship.

The foundation determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Additional research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through

which the small semi-solid smoke particle can easily pass. However, in the exclusive Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. In this maze-like network of super-fine fibers the smoke particle has much less chance to slip through the filter.

Thus, Lorillard research created a filter which reduced tars and nicotine in the "inhaled" smoke to the lowest level among the largest selling brands. As smokers learned about the "MICRONITE" Filter, they changed to Kent. During the past year, for instance, more smokers changed to Kent than to any other cigarette in America.



If you would like for your own use the booklet, "The Story of Kent," write to:

P. Lorillard Company  
Research Department  
200 East 42nd Street  
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Usual medications  
act only here  
↓

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**isoclor**

acts here  
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to relieve both nasal  
.....  
and chest discomfort

NEW

**isoclor**<sup>TM</sup>  
TABLETS AND SYRUP

relieves both / upper respiratory congestion  
bronchial congestion

- **effective** because d-isoephedrine combines both nasal and bronchial decongestant actions<sup>1</sup>—together with the histamine blocking action of chlorpheniramine.
- **fast** . . . clears air passages in 10-20 minutes. Relieves stuffiness, swelling, discharge. Prevents excessive post-nasal drip and resulting night cough.
- **safe** . . . Laboratory studies reveal little effect on CNS or pressor stimulation.<sup>2</sup> Minimal daytime drowsiness or interference with sleep.

1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

TABLETS AND SYRUP for adults and children . . .

COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate.....	4 mg.	2 mg.
d-Isoephedrine HCl.....	25 mg.	12.5 mg.

DOSE: Tablets: Adults: 1 tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d. Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

CHARLES C.

**HASKELL**

& COMPANY,  
Richmond, Virginia



# **“ankle-itis”**

there's pain and  
inflammation here...

it could be mild  
or severe, acute or  
chronic, primary or  
secondary fibrositis — or even  
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

assured anti-inflammatory effect of low-dosage corticosteroid<sup>1</sup> . . . additive antirheumatic action of corticosteroid plus salicylate<sup>2-5</sup> brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

much less likelihood of treatment-interrupting side effects<sup>1-6</sup> . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

**THERAPY SHOULD BE INDIVIDUALIZED**

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



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any  
case  
it calls for  
**Sigmagen<sup>®</sup>**  
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<b>Composition</b>	
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Acetylsalicylic acid .....	325 mg.
Aluminum hydroxide .....	75 mg.
Ascorbic acid .....	20 mg.

**Packaging:** SIGMAGEN Tablets, bottles of 100 and 1000.  
**References:** 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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*relieve the tension—and control its G.I. sequelae*



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meprobamate with PATHILON® tridihexethyl chloride Lederle

*for relieving tension and curbing hypermotility  
and excessive secretion in G. I. disorders*

**PATHIBAMATE** combines two highly effective and well-tolerated therapeutic agents:

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**PATHILON** (25 mg.)—an anticholinergic long noted for producing prompt symptomatic relief through peripheral, atropine-like action, yet with few side effects

*now available...*

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200 mg. meprobamate • 25 mg. PATHILON

*for more flexible control of G. I. trauma and tension  
smooth, sugar-coated, easy-to-swallow*

**PATHIBAMATE-400** and **PATHIBAMATE-200** are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

**Supplied:** **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; **PATHILON** tridihexethyl chloride 25 mg.

**PATHIBAMATE-200**—Each tablet (yellow, coated) contains meprobamate, 200 mg.; **PATHILON** tridihexethyl chloride, 25 mg.

**Administration and Dosage:** **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

**PATHIBAMATE-200**—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

**Contraindications:** glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



# NIAMID<sup>\*</sup>

*the mood brightener*

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**NIAMID** has been found to be strikingly effective and well tolerated in a broad range of depressive states including a wide variety of the milder depressive syndromes, as well as the masked depression so frequently seen in general practice. These syndromes include: depression associated with the menopause, postoperative depressive states and senile depression; depression accompanying chronic or incurable illness, such as gastrointestinal and cardiovascular disorders and inoperable cancer.

### *in angina pectoris*

**NIAMID**, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients—markedly reduces the pain, severity and frequency of anginal episodes, reduces nitroglycerin requirements, and provides an increased sense of well-being. Since dramatic improvement is seen in some patients, it is wise to advise the patient against overexertion—his disorder still holds potential dangers despite relief of symptoms.

**DOSAGE:** Start with 75 mg. daily in single or divided doses. After a week or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others in 7 to 14 days. A few patients may require as much as 200 mg. daily over a longer period of time before significant improvement is seen.

**PRECAUTIONS:** Side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. Hypotensive effects have rarely been noted and no jaundice or other evidence of liver damage has been reported in patients receiving NIAMID. However, in patients with a history of liver disease, the possibility of hepatic reactions should be kept in mind.

**SUPPLY:** NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

### **Already clinically proved in several thousand patients—**

Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request.


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it  
started  
as a  
"cold"...

to prevent the sequelae  
of u.r.i. ... and relieve the  
symptom complex

# ACHROCIDIN<sup>®</sup>

Tetracycline-Antihistamine-Analgesic Compound Lederle

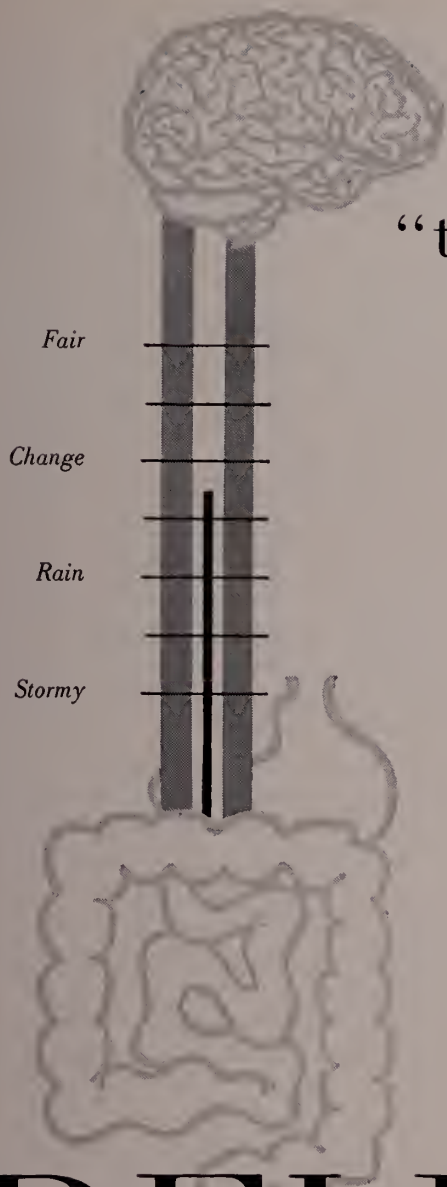
Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or  
bronchitis develops as a serious bacterial complication in  
about one in eight cases of acute upper respiratory  
infection.<sup>1</sup> To protect and relieve the "cold"  
patient...ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm.  
tetracycline). Each TABLET contains: ACHROMYCIN<sup>®</sup> Tetracycline  
(125 mg.); phenacetin (120 mg.); caffeine (30 mg.);  
salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as  
SYRUP (lemon-lime flavored), caffeine-free.

<sup>1</sup> Based on estimate by Van Volkenburgh, V. A., and Frost,  
W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



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“the G-I tract  
is the  
barometer  
of the mind...”

*Belbarb*


*soothes the agitated mind  
and calms the G-I spasm  
through the central effect  
of phenobarbital and the  
synergistic action of  
fixed proportions  
of natural belladonna  
alkaloids on the  
gastrointestinal tract.*

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(Continued from page 508)

bit in all of them. I am most honored to be able to serve under Dr. Ralph W. Jack and his fine officers. I know he will ask for our help whenever he needs it, and we will do our best to help him and the medical association.

Mrs. Wendell J. Newcomb, *President*

## OBITUARIES

### Henry Charles Weber

Dr. Henry Charles Weber of Daytona Beach died on Oct. 30, 1958 at the United States Naval Hospital, Bethesda, Md., following an operation for liposarcoma and meningioma. He was 71 years of age.

Born in Meschede, Germany, in 1887, Dr. Weber received his medical training at Marquette University School of Medicine in Milwaukee, Wis., where he was awarded the degree of Doctor of Medicine in 1914. He later had special training in ophthalmology and otolaryngology at Harvard Medical School in Boston and the Eye, Ear, Nose and Throat Infirmary in New York City. After more than 33 years of active duty in the United States Navy, he retired with the rank of

captain. Locating in Daytona Beach in 1953, he practiced his specialty there for five years until illness necessitated his retirement.

Dr. Weber was a member of the Volusia County Medical Society and since 1954 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and of the American Academy of Ophthalmology and Otolaryngology and was a fellow of the American College of Surgeons.

Surviving are the widow, Mrs. Mabelle R. Weber, of Drexel Hill, Pa.; a daughter, Dr. Beatrice Weber Connelly, of Kensington, Md.; and a brother, Dr. Frank Weber, Arcadia, Wis.

### Clarence Bernstein

Dr. Clarence Bernstein of Orlando died on April 23, 1959. He was 53 years of age.

Dr. Bernstein received his academic schooling at Yale University and his medical training at the Johns Hopkins University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1931. His specialty was internal medicine, and he was a pioneer in the field of allergy. His interest stemmed from basic research on immunology in tuberculosis with Dr. A. R. Rich of the Johns Hopkins University, and later at universities in Chicago he did much original work along lines of antigen-antibody relationships both in animals and in man. Although his professional career was beset by prolonged interruptions because of illness caused by a bronchial adenoma, his scholastic achievements are evidenced by his election to membership in such honor societies as Phi Beta Kappa, Alpha Omega Alpha and Sigma Xi.

After recovery from a successful pneumonectomy and a rejection by the armed forces in the early part of World War II, Dr. Bernstein was assigned by Procurement and Assignment to the Orlando area, which had been seriously depleted of its physicians by the armed forces. Through the ensuing years he continued to practice in Orlando, even under most difficult circumstances after it became apparent in 1956 that he was suffering from a recurrent systemic invasion of the original lesion. Locally, he was an attending physician at the Orange Memorial Hospital, the Florida Sanitarium and Hospital, and the Holiday House Hospital. Active in civic affairs, he was a founder of the Central Florida Symphony Association and served on its Board of Directors.

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He was a founder and President of the Congregation of Liberal Judaism. A member of the Yale Alumni Club of Central Florida, he also held membership in the Executive Club of Orlando, the Committee of One Hundred of Orlando and the Dubsdread Country Club. He was an outstanding national figure in the United World Federalists organization.

Dr. Bernstein was a member of the Orange County Medical Society, the Florida Medical Association, the American Medical Association and the Southern Medical Association. He was an active member of the Chicago Society of Allergy, Institute of Medicine and Central Society of Clinical Research, and was a founder member of the Society for Investigative Dermatology. He was a consultant in medicine at the Institute of Psychoanalysis of Chicago. A fellow of the American Academy of Allergy and the American College of Allergy, he was a member and past president of the Southeastern Allergy Association, and a founder and past president of the Florida Allergy Society. He was a member of the executive committee of the American Academy of Allergy from 1955 to 1958, and illness prevented his ac-

ceding to the presidency of that national organization. In 1957, he was program chairman for the Section of Allergy of the American Medical Association. He was a member of the American Federation of Clinical Research, the American Association for the Advancement of Science and the Florida Academy of Sciences. He was the author of 27 publications in the fields of internal medicine and allergy.

Surviving are the widow, Mrs. Bobbie Bernstein, and two daughters, Jill and Toni, all of Orlando.

### BOOKS RECEIVED

**Physical Diagnosis.** *The History and Examination of the Patient.* By John A. Prior, M.D., and Jack S. Silberstein, M.D. Pp. 388. Illus. 193. Price, \$7.50. St. Louis, The C. V. Mosby Company, 1959.

Believing that the major objective of a course in physical diagnosis is to acquaint the student with the basic "tools of his trade," namely, the history, physical examination, and essential medical terminology, the authors and 10 contributors present their subject with simplicity and brevity in 15 chapters. All are faculty members of the Ohio University College of Medicine. In their experience, there is no substitute for a good history and they teach the student how to obtain an adequate history which, when coupled with the examination, will

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enable him to have a reasonably accurate impression of the possible causes of any given illness. A relatively detailed discussion of the review of body systems is also included to familiarize him with the terminology that is necessary in medicine for ease of communication and to explain the medical significance of the many meaningful clinical terms to which he is being introduced. Discussion of disease is intentionally kept at a minimum as emphasis is placed on appreciation of the normal as essential to the appreciation of the abnormal. The book offers the medical student an excellent guide to obtaining an organized, logical history and to performing a systematic examination.

**Tumors of the Lungs and Mediastinum.** By B. M. Fried, M.D., F.C.C.P. Pp. 467. Illus. 344. Price, \$13.50. Philadelphia, Lea & Febiger, 1958.

In this practical work, the etiology, diagnosis and treatment of nearly all benign and malignant tumors of the lungs, pleura and mediastinum are fully discussed. Cancer of the lungs receives the major emphasis, with particular attention paid to early clinical manifestations. Adenoma of the bronchus, pleural tumors, and less common tumors of the lungs and mediastinum are considered fully. Tumors of the lymphoid tissues, such as reticulum cell sarcoma, lymphosarcoma, and Hodgkin's disease; tumors of the thymus gland, neurogenic tumors, teratomas and cysts are described in detail and amply illustrated. Two chapters are devoted to radiographic diagnosis. Metastases to the lungs from visceral cancers and from lung cancer to visceral organs are discussed and illustrated with roentgenograms. The description of each tumor is preceded by a delineation of the anatomy and physiology of the organ which gave rise to the new growth. The possible role of environmental factors and occupation in the emergence and rapid rise of lung cancer is detailed, and the role of cigarette smoking in the genesis of the malignant pulmonary disease is discussed. Because

the book considers tumors of the lungs and mediastinum from their earliest appearance and includes causative factors, it is of interest to all physicians—internists as well as general practitioners, thoracic surgeons and chest specialists as well as radiologists.

**Handbook of Cardiology for Nurses.** By Walter Modell, M.D., F.A.C.P., and Doris R. Schwartz, B.S., R.N. Ed. 3. Pp. 328. Price, \$4.50. New York, Springer Publishing Company, Inc., 1958.

This third edition of the only cardiology book written specifically for nurses contains new information and guidance particularly in the portions dealing with drug treatment and surgery and in the added chapter on nursing care before and after cardiac surgery. The aim remains unchanged: to present cardiology and nursing of the cardiac patient as a nurse must know it to do her work with skill and authority. The details of modern cardiac therapy are presented so that she can readily follow any therapeutic plan with any doctor and be an expert in each case. The important functions a nurse has in cardiac complications and emergencies are discussed explicitly.

**Practical Leads to Puzzling Diagnoses. Neuroses That Run Through Families.** By Walter C. Alvarez, M.D., D.Sc. Pp. 490. Price, \$9.00. Philadelphia, J. B. Lippincott Company, 1958.

In this book, the author, in his clear and familiar style, suggests how a better knowledge of a patient and his family, gained through the expenditure of a few minutes in eliciting a more complete history, can save the physician much time lost in fruitless treatment of the organic symptoms of basically psychosomatic conditions. The diagnostician adept in the recognition of the signs pointing toward these conditions will find the handling



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Zack Russ, M.D.

Walter Bailey, M.D.

Arturo Gonzalez, M.D.

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A close-up photograph of a human hand, palm facing forward, with the index and thumb fingers extended and slightly curved. A small, red, oval-shaped pill is held between the tips of these two fingers. The background is a plain, light-colored surface.

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\*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.<sup>1</sup>

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with far less antibiotic intake

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1. Hirsch, H. A., and Finland, M.: Antibacterial Activity Of Serum Of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959. 2. Hirsch, H. A., Kunin, C. M., and Finland, M.: Demethylchlortetracycline - A New And More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. To be published. 3. Lichter, E. A., and Sobel, S.: The Distribution Of Oral Demethylchlortetracycline In Healthy Volunteers And In Patients Under Treatment For Various Infections. To be published. 4. Kunin, C. M., Dornbush, A. C. and Finland, M.: Distribution And Excretion Of Four Tetracycline Analogues In Normal Young Men. To be published. 5. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Capacity. *New England J. Med.* 259:999 (Nov. 28) 1958. 6. Sweeney, W. M.; Hardy, S. M.; Dornbush, A. C., and Rueggsegger, J. M.: Demethylchlortetracycline: A Clinical Comparison of A New Antibiotic with Chlortetracycline and Tetracycline. *Antibiotics & Chemotherapy* 9:13 (Jan.) 1959.

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**Maternity.** *A Guide to Prospective Motherhood.* By Frederick W. Goodrich, Jr., M.D. Pp. 130. Price, \$1.75. New York, Prentice-Hall, Inc., 1959.

This concise handbook for the mother-to-be is designed as a reference to supplement her doctor's care and to underline his instructions. It provides a clear, accurate explanation of pregnancy, labor and childbirth—from the first sign and symptoms through delivery. This source of authoritative information should serve as a helpful aid in the doctor-patient relationship for it answers simply, but soundly, the questions the doctor may not have time to cover fully in private consultation.

**Current Therapy—1959.** *Latest Approved Methods of Treatment for the Practicing Physician.* Edited by Howard F. Conn, M.D. Pp. 781. Price, \$12.00. Philadelphia, W. B. Saunders Company, 1959.

With this volume, Current Therapy begins its second decade of publication. For general physician and specialist alike, this 1959 volume provides a full measure of readily accessible up-to-date help on specific therapeutic methods for management of practically all common diseases and disorders. More than 300 carefully selected contributors present in simple terms what they consider the best way to treat a wide variety of illnesses. These problems range from alleviating the common cold to managing complications of multiple sclerosis. Some 282 articles, nearly 75 per cent of the text, are improved in some significant manner over last year. They are either written by a new author presenting a different viewpoint, show latest refinements in technic, or contain completely new and better treatments than the best known last year for particular disorders. Floridians among the contributors include Drs. Robert E. Cassidy, James H. Ferguson and George D. Lilly of Miami, George T. Harrell of Gainesville, Sanford Levine of Miami Beach, and Henry L. Smith Jr. of Tallahassee.

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* Bradford, Gilchrist, Union				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	33
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	67
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	246
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	6
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* Baker				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	961
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	27
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	359
* Clay				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	116
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	243
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	38
* Sumter				
Lee-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-				
Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	81
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* Levy				
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Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	9
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* Osceola				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	181
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	19
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	307
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	133
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
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Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
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* Flagler				
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November, 1959  
Vol. XLVI - No. 5

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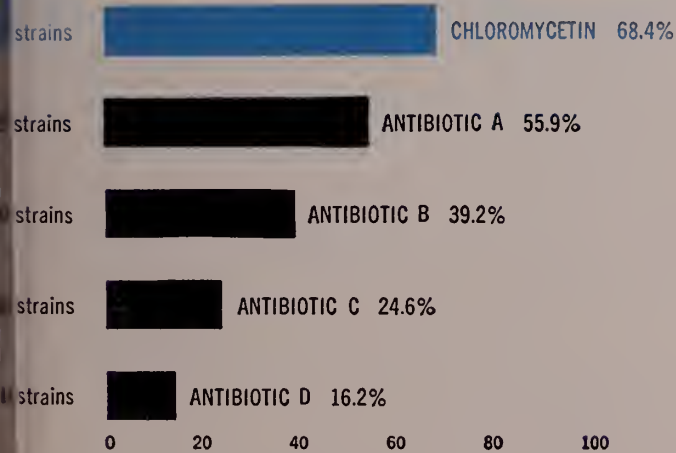
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**REFERENCES:** (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (2) Suter, L. S., & Ulrich, E. W.: *Antibiotics Chemother.* 9:38, 1959. (3) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616, 1958. (4) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (5) Horton, B. F., & Knight, V.: *Tennessee M. A.* 48:367, 1955. (6) Sencea, H.: *Am. Pract. & Digest Treat.* 10:622, 1959. (7) H. W. H.: *M. Clin. North America* 43:191, 1959. (8) Sencea, H., et al.: *J. Urol.* 81:324, 1959. (9) Wolfsohn, A. W.: *Connecticut M.* 22:769, 1958.



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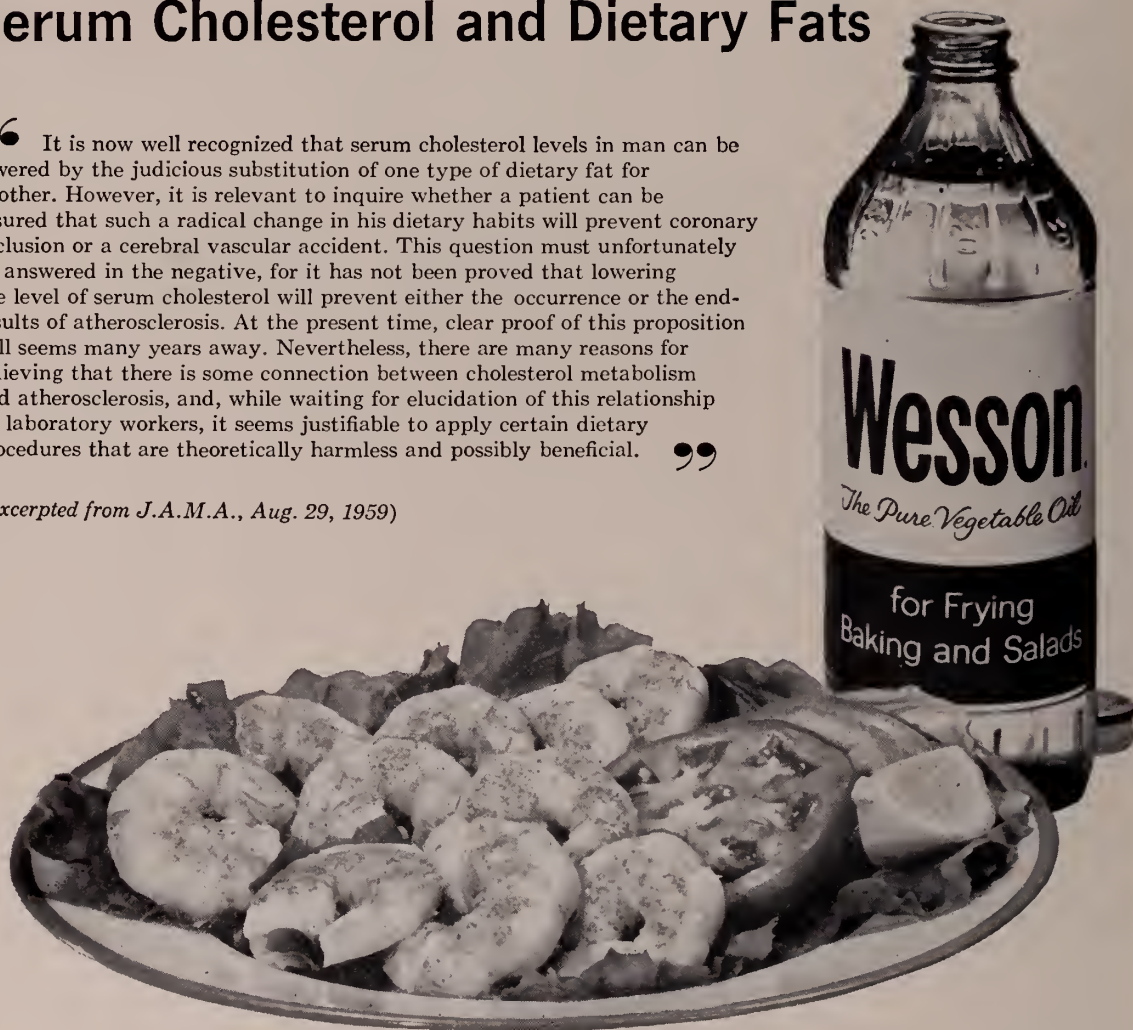
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## A Significant Statement about Serum Cholesterol and Dietary Fats

“ It is now well recognized that serum cholesterol levels in man can be lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial. ”

(Excerpted from *J.A.M.A.*, Aug. 29, 1959)



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Riboflavin	3 mg.
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*References:* 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

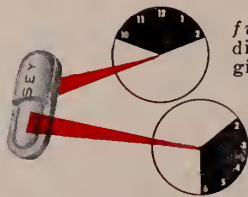
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*References:* 1. Aries, P. L.: J.A.M.A. 169:703 (Feb. 14) 1959. 2. Personal Communication on file at Medical Department, Wampole Laboratories. 3. Reports of clinical trials by 9 physicians.

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1. Hirsch, H. A., and Finland, M.: Antibacterial Activity Of Serum Of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959. 2. Hirsch, H. A., Kunin, C. M., and Finland, M.: Demethylchlortetracycline — A New And More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. To be published. 3. Lichter, E. A., and Sobel, S.: The Distribution Of Oral Demethylchlortetracycline In Healthy Volunteers And In Patients Under Treatment For Various Infections. To be published. 4. Kunin, C. M., Dornbush, A. C. and Finland, M.: Distribution And Excretion Of Four Tetracycline Analogues In Normal Young Men. To be published. 5. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Capacity. *New England J. Med.* 259:999 (Nov. 28) 1958. 6. Sweeney, W. M.; Hardy, S. M.; Dornbush, A. C., and Rueggesser, J. M.: Demethylchlortetracycline: A Clinical Comparison of A New Antibiotic with Chlortetracycline and Tetracycline. *Antibiotics & Chemotherapy* 9:13 (Jan.) 1959.

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1. Goodman, L.S. and Gilman, A.: *The Pharmacologic Basis of Therapeutics*, MacMillan, 1955.



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2. Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)  
3. Scheinberg et al: Surgery 24:972, 1948 (Dec.).

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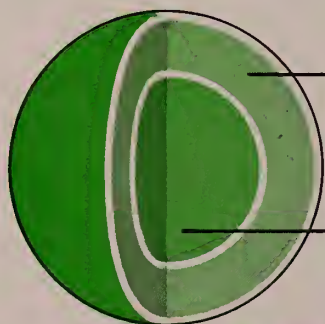




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rt, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.*: *Am. J. Psychiat.*  
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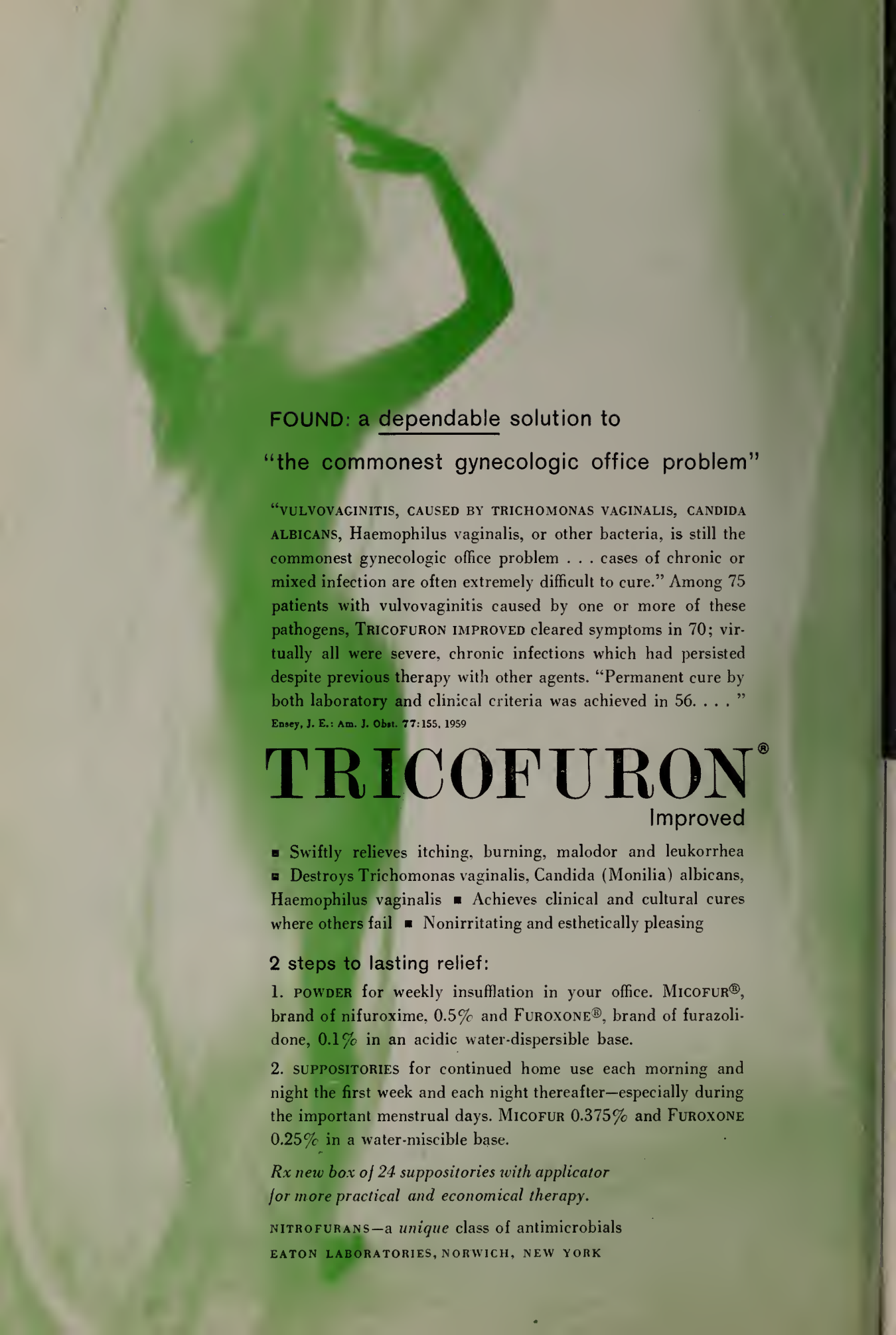
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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## Spontaneous Pneumothorax *Its Complications and Treatment*

NELSON H. KRAEFT, M.D.  
TALLAHASSEE

Certain misconceptions persist concerning the etiology and significance of spontaneous pneumothorax despite factual information which has been recorded over 25 years.<sup>1</sup> Additional confusion often attends the treatment of the patient. A brief review of a series of 32 patients with spontaneous pneumothorax treated at Tallahassee Memorial Hospital by various members of the medical staff from August 1953 to November 1958 forms the basis for re-emphasis of some important points concerning this disease.

### **Etiology**

The great majority of cases of spontaneous pneumothorax are due to rupture of a subpleural bleb. The blebs are located usually at the apices of the lobes and along the edges of the fissures between the lobes of the lungs. The factors causing their formation are unknown, but they are probably due to valvelike obstructions in the bronchioles supplying the area.<sup>2</sup> Bullous emphysema and generalized emphysema are much less commonly complicated by pneumothorax. At times spontaneous pneumothorax results from rupture of perivascular alveoli with dissection of the free air back into the mediastinum and then into the pleural space.<sup>3</sup> This mechanism probably explains many instances of pneumothorax when no cause is apparent at open thoracotomy.

In times past, advanced pulmonary tuberculosis was commonly complicated by spontaneous pneumothorax, and therefore anyone whose lung collapsed was suspected of having tuberculosis. Spontaneous pneumothorax, however, has never been a manifestation of otherwise occult pulmonary tuberculosis. When the chest roentgenogram shows no evidence of parenchymal disease, the

patient should not be suspected of having pulmonary tuberculosis, nor is tuberculosis any more likely to develop in the future than in the average person.

Physical exertion is not a factor in etiology since the collapse occurs often with the patient sitting quietly or even asleep in bed.

### **Diagnosis**

The history of sudden onset of pain in the chest followed by dyspnea is characteristic and common. Unless pleural adhesions are present, the pain is usually of short duration and is aggravated by respiration and by marked changes in position. The symptoms sometimes suggest those of coronary occlusion or of an upper abdominal insult.

The clinical picture varies from mild apprehension to collapse in a shocklike state. With collapse of small degree the classical physical signs of pneumothorax may be absent or easily missed. In the presence of extensive pulmonary emphysema collapse of one lung results in little apparent change in the already depressed breath sounds.

The chest roentgenogram is diagnostic although a minimal degree of collapse is easily overlooked. Exposing the chest film at the end of expiration is a simple method of accentuating a questionable pneumothorax since the degree of collapse is increased by the higher intrapleural pressure of expiration. At times areas of bullous emphysema are difficult to differentiate from pneumothorax on the roentgenogram, but fluoroscopic examination will aid the decision. Rarely, the gas-filled stomach which is herniated into the chest as a result of trauma is mistaken for a pneumothorax (fig. 1). The causative trauma

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Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

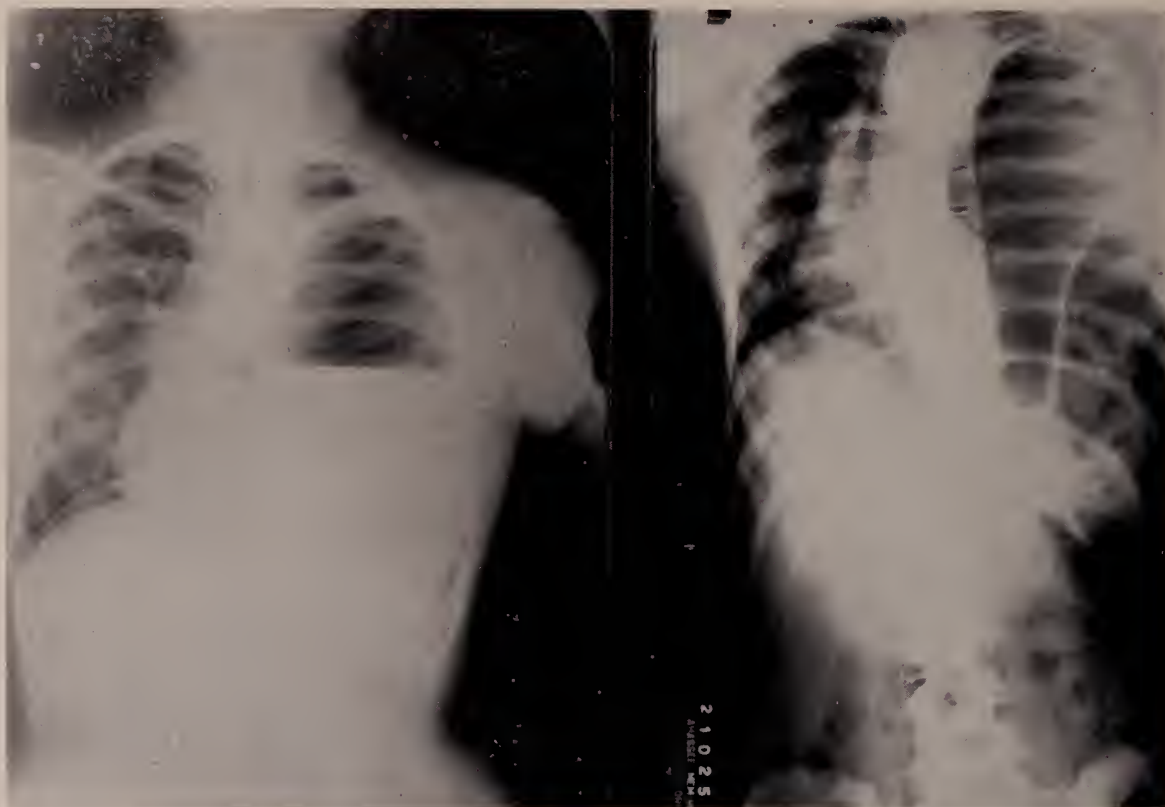


Fig. 1.—A. Apparent pneumohydrothorax, left. B. Actual situation of gas-filled stomach and bowel herniated through diaphragm into chest as seen with patient supine, barium in esophagus (which reproduces poorly.)

may have been mild and remote enough that the “pneumothorax” seems unrelated to the injury.

#### Complications

Spontaneous pneumothorax is a disorder characterized by recurrence. Its complications also include the development of positive intrapleural pressure or “tension” pneumothorax, failure of the lung to re-expand, and bleeding into the pneumothorax space as a result of torn adhesions. Small amounts of bloody or serous fluid in the pneumothorax space are common, but the appearance of sizable amounts of serous fluid indicates an associated pulmonary inflammatory disease. Massive bleeding is relatively uncommon, but it is a serious threat when unrecognized or improperly treated. Simultaneous bilateral collapse, while uncommon, is ominous and requires urgent treatment.

#### Treatment

Probably much of the confusion concerning the proper treatment of the patient with spontaneous pneumothorax stems from the fact that most of the patients will recover spontaneously over a variable period of time. The patient who has a small pneumothorax (less than 30 per cent)

and who has minimal or no symptoms needs no special treatment. He need not be confined to bed nor restricted from normal, nonstrenuous activities.

The patient whose pneumothorax is increasing or fails to re-expand, or whose pain and dyspnea are persistent or progressive, or whose pneumothorax compromises a lung already impaired by emphysema needs prompt, active treatment. Oxygen has little place in therapy except as a temporary expedient. The patient with a symptomatic pneumothorax requires restoration of his ventilatory capacity, not additional oxygen in the respired air. This restoration is rapidly and easily accomplished by the insertion of a catheter into the pleural space. The catheter is connected to a water seal drainage bottle. The catheter is easily inserted with simple instruments readily available (fig. 2): a needle and syringe for the local anesthetic, a scalpel for the half inch skin incision, and a hemostat for blunt dissection through the chest wall into the pleural space usually in the first or second intercostal space anteriorly. A catheter with a distal inflatable bag is preferable since the tip is accurately placed and maintained against the chest wall.



Usually the lung re-expands rapidly, often in a matter of minutes. At times it is necessary to apply continuous suction with a pump to obtain re-expansion. Needle aspiration of the pneumothorax may be performed, but it is often impossible to aspirate the air faster than it escapes into the pleural space through the rent in the lung, and there is always the danger of causing additional perforations of the visceral pleura. The use of an indwelling needle for decompression is of little value since even large bore needles are too small to allow rapid escape of air and the possibility of visceral pleural injury persists.

Infection of the pleural space due to insertion of a catheter need not be feared. No infection has occurred during a period of 10 years' experience with this procedure.<sup>4</sup> After the catheter ceases to function, it is removed if the lung has re-expanded, and an air-tight dressing is applied to the wound. Care is taken to prevent entrance of air through the wound during this removal.

The rapid re-expansion of the lung is not undesirable since it promotes healing of the pleural defect by sealing against the chest wall. The admonition sometimes heard to "remove just a little air at a time so as not to interfere with healing of the ruptured bleb" is ill-founded and merely prolongs the period of treatment.

Table 1. — Analysis of Series

Treatment	Patients	Admissions	Range	Age
				Average
Conservative	11	13	22-49	40+
Catheter	17	17	18-72	38+
Thoracotomy	8	9	22-49	36+
Totals	32	39	18-72	40

Of the 32 patients in the present series (table 1), 11 had 13 admissions during which only conservative treatment was used. Seventeen patients were treated by catheter evacuation of the pneumothorax. Two of these had previous admissions with conservative treatment. The average period of hospitalization was about five days with each group, but those patients treated by catheter were discharged with the lung completely re-expanded and ready to return to work (fig. 3).

The use of decompression is imperative for tension pneumothorax and it allows prompt discovery of the patient whose lung will not re-expand without operation. The catheter is also advised for evacuation of hemothorax. Needle aspiration is tedious and often difficult or impossible to complete because of clots. The catheter also al-



Fig. 2.—The few, simple, readily available instruments necessary for catheter decompression of the chest.

lows easy determination of whether the bleeding has ceased.

Three patients in this group had massive bleeding with losses of from 1½ to over 4 liters of blood. Two of them responded to catheter evacuation of the blood and air while one required open thoracotomy.

#### Open Thoracotomy

Treatment by open thoracotomy is indicated for multiple recurrences, for persistent or chronic pneumothorax and for persistent bleeding.

There is no magical number determining when one should advise operation for recurrent pneumothorax. Usually the patient who has three or more episodes should be considered for open thoracotomy, but the decision for or against naturally rests on many factors beyond the number of episodes. Commonly, subpleural blebs or subsegmental areas of emphysema are found at

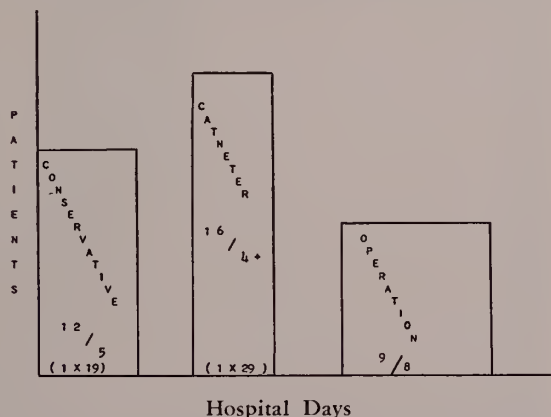


Fig. 3.—One patient omitted from graph of conservative treatment since hospitalization was prolonged by unrelated disease. Another patient was omitted from graph of catheter treatment since hospitalization was prolonged by severe emphysema. These are indicated in parentheses at the base of graphs.

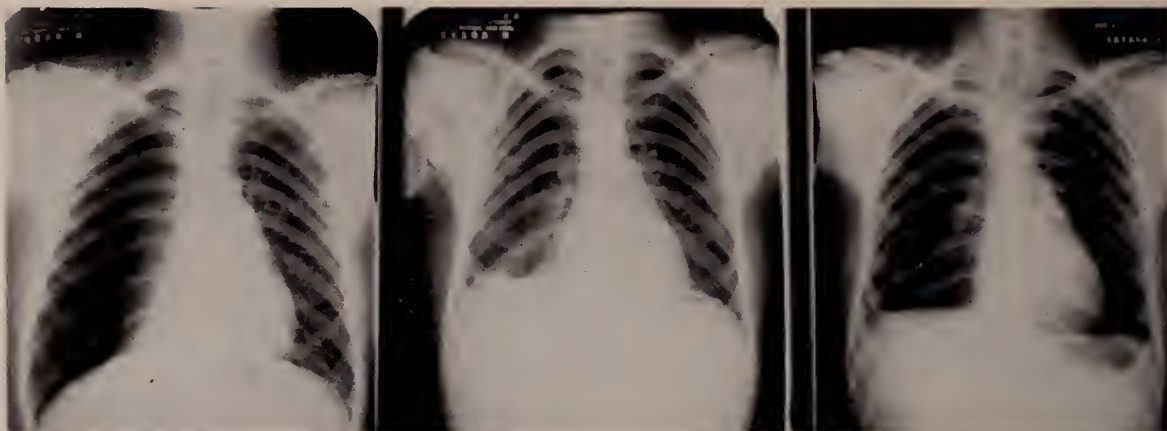


Fig. 4.—A. Spontaneous pneumothorax, right, with 60 per cent collapse. B. Appearance 24 hours after catheter decompression, lung completely re-expanded. C. Appearance one month after bilateral excision of bullae and removal of parietal pleura.

operation. The leaking point may or may not be found. The blebs are removed or obliterated by sutures, and conservatism is exercised in any removal of lung tissue. Following this procedure the parietal pleura is rubbed with dry gauze, or it is stripped from the chest wall and removed. In the absence of old inflammatory disease residuals, the latter procedure is easily and rapidly performed with minimal loss of blood and it gives greater assurance of obliteration of the pleural space. In addition to preventing recurrence, obliteration of the pleural space improves the blood

supply to the lung, thereby perhaps preventing extension of the emphysema. Obliteration of the pleural space in this manner does not reduce the ventilatory function of the lung in significant degree.<sup>5</sup>

Open thoracotomy is also indicated for chronic pneumothorax and for cases in which re-expansion cannot be gained by catheter decompression. The chronic pneumothorax lung either has a persistent fistula which must be closed, or it is encased in a fibrous peel which must be removed. Probably in most cases of pneumothorax the lung

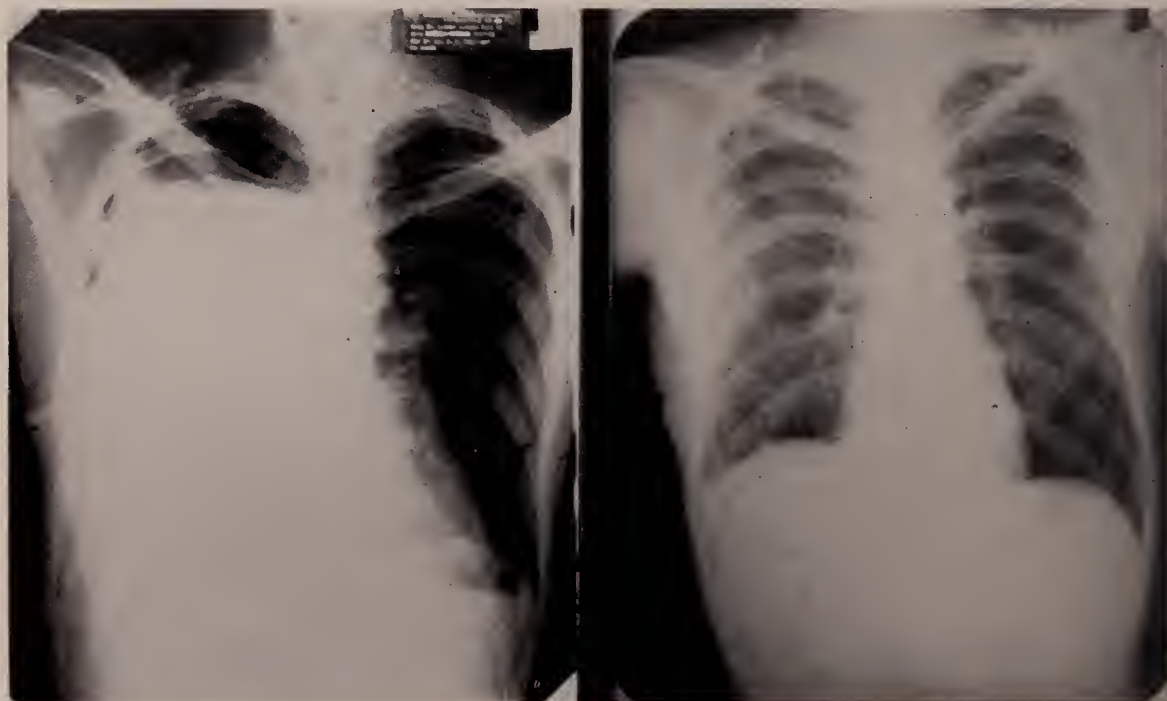


Fig. 5.—A. Right lung completely collapsed, pleural space filled with clotted blood despite catheter drainage of 3 liters of blood. B. Appearance at discharge six days after thoracotomy for removal of more than 1 liter of clotted blood, suture of bleeding point, excision of pulmonary blebs, and removal of parietal pleura.



can be re-expanded by persistent use of continuous suction applied to an intercostal catheter. In some instances prolonged efforts with suction may be preferable to open thoracotomy, particularly when there is extensive bilateral emphysema. Pumps capable of delivering a high volume of flow must be used. Again, the possibility of infection is small provided obliteration of dead space is attained. In the absence of contraindications to operation, however, open thoracotomy permits accurate correction of the defect plus measures which will prevent recurrence.

Finally, thoracotomy for the patient who bleeds continuously from torn adhesions may be life-saving. Even though the bleeding occurs from small systemic vessels, it can be stopped if the lung can be re-expanded to act as a tampon against the bleeding point. This is accomplished most quickly with an intercostal catheter. When bleeding persists despite catheter drainage, or when large amounts of blood remain in the pleural space, open thoracotomy is indicated. The estimated 20 per cent mortality of patients with massive bleeding<sup>6</sup> should be reducible by adequate blood replacement and aggressive treatment. The preoperative, pale, clammy, dyspneic patient makes a sharp and gratifying change with replacement of the blood loss, control of the bleeding, and restoration of the ventilatory capacity by evacuation of the intrapleural blood. We have not been satisfied with the use of enzymatic agents for mobilizing clotted blood in the chest. Such agents present the danger of restarting bleeding as well.

Of the eight patients subjected to open thoracotomy, five had experienced from three to seven episodes of spontaneous pneumothorax. One of these eight had bilateral, consecutive procedures with an interval of one month between them (fig. 4). In four instances, multiple blebs were found. In the fifth patient, the only woman in the group, no apparent cause for the recurrent pneumothoraces was found.

Two of the patients were operated upon because of failure of catheter drainage. The eighth patient, operated on because of continued bleeding despite evacuation of over 4 liters of blood, had a spurting vessel 1 mm. in diameter located in the extreme apex of the pleural space (fig. 5). There was no mortality in this group, and the average hospital stay was eight days.

Only one patient in the group of 32 died in the hospital. This patient had severe heart dis-

ease, and his small pneumothorax, treated conservatively, probably played no part in his demise.

### Summary and Conclusions

A series of 32 patients with the diagnosis of spontaneous pneumothorax having 39 hospital admissions is briefly reviewed.

Spontaneous pneumothorax occurs as a result of rupture of subpleural, or rarely perivascular, blebs. Exertion is not a factor in etiology.

In the absence of roentgenologic evidence of parenchymal disease the patient with spontaneous pneumothorax does not have pulmonary tuberculosis, nor does the pneumothorax indicate predisposition to this disease.

The diagnosis may be suspected from the history, supported by the physical findings and proved by the roentgenogram.

Bed rest and oxygen should have little part in treatment. The asymptomatic patient with non-progressive pneumothorax should be allowed moderate activity. It is economically wasteful and therapeutically useless to keep such a patient at rest.

The symptomatic patient and those with persistent or progressive collapse should be treated actively by mechanical evacuation of the pneumothorax.

Multiple recurrences, chronic pneumothorax, persistent pleural air leaks, bilateral collapse, tension pneumothorax and massive hemorrhage are complications which usually require operative intervention.

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### Discussion

DR. RODES C. GARBY, St. Petersburg: I have enjoyed Dr. Kraeft's presentation of a problem which is common. I would like to emphasize one point and take exception to a couple of lesser points which might be important upon occasion.

As regards diagnosis, I am sure that many spontaneous pneumothoraces are not diagnosed because the symptoms and signs are not severe enough to be characteristic. The



complaint of the patient is passed off as being one of the occasional twinges of pain to which the human body is subject. On the other hand, in some of the patients the findings are strikingly similar to those of patients with acute coronary thrombosis. On more than one occasion I have been asked to see a patient with spontaneous pneumothorax who was admitted under the presumptive diagnosis of coronary occlusion, and the true diagnosis was established only because routine x-ray showed a pneumothorax. This is especially true when a pneumothorax occurs in a person in the older age group with an emphysematous chest, with breath sounds distant even on the uncollapsed side. Awareness of the condition and an x-ray will make the diagnosis apparent. It is interesting that this condition occurs rather definitely in a younger and an older age group, and is considerably less common in the middle years.

I would like to issue a word of caution on the matter of no therapy or restriction of activity in the patient in whom a small pneumothorax is found. If such a patient were asthmatic and experienced an asthmatic attack, he could rapidly increase the small pneumothorax to dangerous extent. Also, even a small leak in a person taking a plane trip might put the patient in dire straits before medical help became available. I believe that these patients should be kept under close surveillance—for medicolegal protection if for no other reason.

The other point that I would like to bring up is in regard to Dr. Kraeft's statement that exertion is not a factor. About five years ago I had occasion to treat a 22 year old man who suffered his second "spontaneous" pneumothorax at exactly the moment he was lifting a cigarette vending machine, and his first episode of pneumothorax had occurred on the same side under exactly similar circumstances. In spite of conservative therapy by closed thoracotomy tube drainage, the pneumothorax kept recurring each time the tube was removed, and it was necessary to perform a thoracotomy to control the situation. While in general I agree that the majority of the spontaneous pneumothoraces are not caused by violent activity, but are actually much more apt to occur when the patient is at rest, I thought that this was an exception to the rule and supported his claim that his medical expenses should be covered by unemployment compensation insurance.

I would like to compliment Dr. Kraeft on his excellent presentation of this important problem.

DR. LAWRENCE C. MANNI, Tallahassee: It appears that Dr. Kraeft has covered the subject well and has made it difficult to raise any questions for argument. I am impressed by the relatively large number of cases reported in a five year period in a community the size of Tallahassee. I would presume that there are many more cases not diagnosed because of lack of symptoms and also those misdiagnosed because a chest x-ray is not taken.

The question of bed rest for all the patients, even those not requiring aspiration of air, might still be raised. I think this goes back to the teaching of several years ago that all cases of spontaneous pneumothorax were due to tuberculosis and bed rest and collapse

therapy were the treatment of the day. Many of the patients were maintained on pneumothorax for months without any parenchymal evidence of tuberculosis. There may still be some who think bed rest is necessary in those cases not requiring aspiration.

Irritation of the pleura is mentioned in open thoracotomy, but not in those cases in which aspiration is done by catheter. The advisability of using an injection of whole blood or 50 cc. of 50 per cent glucose into the pleural space as an irritant followed by catheter decompression might be questioned, and I would like Dr. Kraeft's comments on this and also on the use of talc when open thoracotomy is performed.

May not the use of enzymatic agents be justified in certain cases when it is advisable not to perform open thoracotomy or a decortication?

The patients having this condition that I have seen seem to fit into a certain category. The majority have been white men ranging in age from 20 to 45 and rather tall and thin and what we call "high strung." I wonder if this has been true in Dr. Kraeft's series of cases.

In conclusion, I would like to re-emphasize the importance of getting the air out of the pleural space and re-expanding the lung when there is any indication of continuous leakage. This should be done by catheterization and not by needle aspiration. Also, open thoracotomy should be performed when there have been repeated attacks and the damaged area of lung has been repaired or removed because spontaneous pneumothorax can cause death.

I wish to compliment Dr. Kraeft on his presentation of a subject dealing with an entity which happens frequently and in some instances requires emergency measures, but a subject which has not been reported in the literature to a great extent.

DR. KRAEFT, closing: I wish to thank Dr. Garby, Dr. Manni and Dr. Seiler for their discussion and for emphasizing some of the points omitted from the paper because of the time limit. Dr. Garby has reminded us of the fallacy of using "never" or "always" in discussion of things medical. Spontaneous pneumothorax can be related to exertion, but this is uncommon in our experience. In allowing the patient to resume normal, mild activities I did not wish to imply that he be dismissed from treatment or observation, but I hoped to emphasize that bed rest prolonged for weeks and even months is unnecessary.

In answer to Dr. Manni's question concerning the use of intrapleural irritants to promote pleural symphysis, there are two reasons why they should not be used: (1) they are frequently ineffective, and (2) they may impair ventilatory function through formation of excessive scar tissue. Dr. Manni has also pointed out that spontaneous pneumothorax is not always a simple, benign disease.

Dr. Seiler has illustrated some of the more unusual manifestations of this disease. The infrequency of the disease in Negroes is also apparent in Tallahassee where, during the period covered in this report, only two patients were treated at Florida A & M University Hospital in contrast to the 32 treated at Tallahassee Memorial Hospital.

# The Artificial Kidney

## A Practical Therapeutic Adjunct

JULIAN G. SUHRER JR., M.D.  
JACKSONVILLE

The artificial kidney is being employed more and more in modern community hospitals. It is a practical therapeutic adjunct in the over-all management of acute and chronic renal failure, severe barbiturate and other poisonings, and intractable pulmonary edema. Its use in ammonium poisoning in hepatic coma<sup>1</sup> and in one case of diabetic acidosis<sup>2</sup> has been described.

### Kolff Coil Kidney

The term "artificial kidney" has for many years implied a cumbersome, highly complicated, but theoretically plausible device requiring a large team of highly skilled personnel to operate and to maintain. In the Kolff stationary twin coil kidney one sees the principle of extracorporeal circulation with differential diffusion and ultrafiltration across a semipermeable membrane utilized with a minimum of technical array.<sup>3-8</sup> The sterile disposable coil and connecting tubing and the standardization of the rinsing solution whereby one corrects the dialyzable components of the blood toward normal assure a measure of safety not generally appreciated. The only constituent of the bath requiring variation with some frequency is the potassium to prevent its too rapid removal in digitalized patients with hyperkalemia. The importance of constant monitoring of the electrocardiogram during dialysis is stressed in many centers, and it is employed routinely by the dialysis team at Baptist Memorial Hospital. On occasion the sodium content would require adjusting to prevent too rapid correction of a low serum sodium.

The management of fluids and electrolytes is much more demanding before and after dialysis than during the procedure itself. The machine corrects the dialyzable components of the blood only toward normal. Before and after dialysis, the physician must constantly guard against overcorrection and undercorrection. The most frequent errors here are overhydration during

the anuric phase of acute renal failure and improper replacement of electrolytes during the diuretic phase. The former error may enhance the possibility of the latter.

The usual duration of dialysis is six hours with an additional two or three hours required in preparing the cutdowns, in priming the machine, and in the final closure of the wounds. The problem of the time required for the procedure shrinks in the face of the therapeutic benefit obtained when dialysis is used with a judicious understanding of the indications and contraindications involved.<sup>5, 7, 9-11</sup>

### Ultrafiltration

The ability of the coil kidney to ultrafiltrate as well as to dialyze renders it of additional value in edematous patients, especially in cases of intractable pulmonary edema. Up to 4,000 cc. of fluid can be removed during a six hour period. The rate of ultrafiltration is controlled by varying the hydrostatic pressure in the coils by means of a simple screw clamp adjustment on the venous outflow tubing. In patients in whom fluid removal is not desired, intravenous replacement of obligatory ultrafiltrate, approximately 300 cc. per hour, is easily accomplished. Weighing the patient before and after dialysis is a valuable aid in estimating fluid loss. An in-bed scale in this regard is very useful.

### Heparinization

The use of heparin as an anticoagulant during hemodialysis has been largely shorn of its frightening implications with the smaller doses now required (smooth polyvinyl chloride tubing) and because of the use of regional heparinization<sup>12, 13</sup> whereby the heparin in the extracorporeal blood is neutralized as it returns to the patient by the addition of protamine sulfate. With regional heparinization the clotting time can be constantly controlled and brought to normal levels at the termination of the procedure. Regional heparinization has permitted hemodialysis in patients in whom it may have been otherwise contraindicated because of a history of bleeding peptic ulcer,

From the Baptist Memorial Hospital, Jacksonville, Fla.

The artificial kidney employed in this study (Travenol Laboratories, Morton Grove, Ill.) was donated by the Baptist Memorial Hospital Auxiliary.



recent operation, et cetera. Whether its application will permit the use of hemodialysis as a post-operative adjunct in neurosurgical patients with chronic renal failure who require intravenous urea in large amounts to reduce intracranial pressure remains to be seen, but is worthy of consideration.

### Blood Requirement

Of the four, sometimes five, units of blood requested for the procedure, two are used for priming or filling the machine and a third remains attached to a side arm in the circuit to permit further increments if necessary. A portion of this third bottle may be required for the initial priming. The fourth bottle is kept overnight in the event of unexpected bleeding and can usually be released the next day. Each of the four bottles of blood requested from the blood bank should be cross-matched with the other three as well as with the patient since in priming the machine, two bottles, and sometimes a portion of a third, are mixed together without being diluted by the patient's blood volume. In smaller children, the volume of extracorporeal blood can be reduced by utilizing a single coil of the twin coil kidney.<sup>14</sup> This is simply done by clamping off the connecting tubing of the other coil with hemostats.

### Other Dialyzers

Other forms of dialyzers have been described and used successfully. A study of the comparative merits of the rotating drum model originally described by Kolff and modified by others and the Kolff stationary twin coil kidney has been made by Merrill and his associates.<sup>3</sup> The dialyzer of Skeggs, Leonards, and Heisler, which requires special assembly, has been used satisfactorily by some groups,<sup>13</sup> but has been abandoned by others.<sup>5</sup> The chief merit of the blood dialyzer of MacNeill and Collins seems to be the very small amount of blood flowing through the extracorporeal circuit eliminating the need for initial priming of the dialyzer with transfusion blood. This advantage would also have special value in dialyzing small children since shifts in blood volume between the patient and the dialyzer would be minimized. The basic principle of differential diffusion across a semipermeable membrane (cellophane) is the same in all of these dialyzers. In our opinion, the greater popularity of the coil kidney is due to its excellent performance and completely disposable units with no clean-up or reassembly necessary.

### Hemodialysis in Acute and Chronic Renal Failure and Severe Poisoning

The role of hemodialysis in acute renal failure is briefly that of helping to maintain the status quo by combating hyperkalemia, acidosis, and too great an accumulation of metabolites in the hope that, with the additional time thus provided, tubular regeneration and normal kidney function may return.<sup>5,9-11,13,15-22</sup>

In chronic renal failure (chronic glomerulonephritis, chronic pyelonephritis, polycystic kidney disease<sup>23</sup>) dialysis is employed for the relief of symptoms due to chemical derangement and not just for the correction of chemical deviations from the normal.<sup>5,7,10,11,17,24</sup> The latter deviations may represent compensatory values for the partially functioning kidneys and dialysis would not be indicated. In the uremic syndrome with renal decompensation, dialysis may improve the clinical picture dramatically and, if the decompensation represents an acute exacerbation of renal failure secondary to infection or other metabolic disturbance which can be controlled, then dialysis offers the hope of recompensation and clinical remission. This is especially true if the urinary output has remained adequate prior to the acute episode and if hypertension and cardiovascular disease is not too severe. The duration of remission is difficult to predict. Careful selection of patients is important since, of course, hemodialysis can not alter the course of terminal renal failure or of severe cardiovascular disease with which renal failure is unfortunately frequently associated.

### Nonrenal Cases

The artificial kidney has been used with considerable success in the treatment of severe poisoning with barbiturates, salicylates, glutethimide (Doriden), bromides, and other diffusible substances. These agents can be removed from the blood at rates up to twenty times that of the normal kidneys. Hemodialysis is indicated when there is persistent or progressively deepening coma with loss of deep tendon reflexes and the corneal reflex. These patients frequently awaken during dialysis and their hospital stay is remarkably shortened.<sup>17,25-28</sup>

Although the artificial kidney is used most frequently in adults, children with renal failure or poisoning with diffusible substances will occasionally require dialysis.<sup>14,29-31</sup>

### Report of Cases

The first three cases treated with hemodialysis at Baptist Memorial Hospital are presented to



illustrate some of the problems involved. In the first case, dialysis was employed three times and in the other two cases only once.

Case 1.—A 24 year old white man was admitted to the orthopedic service at Baptist Memorial Hospital on March 29, 1959, after a motorcycle-automobile accident in which he sustained compound fractures of the left upper femur and left lower tibia and fibula. There were also fractures of the mandible, both hands, and the right wrist.

Shock responded to whole blood transfusions, and the compound fractures were debrided and immobilized on admission. Severe oliguria ensued, and on April 3, five days after the accident, he began having severe convulsions. The blood pressure was 170/100 mm. Hg. Dialysis was carried out for six hours. Table 1 shows the blood chemistry before and after the procedure. No further convulsions occurred, and the general clinical condition improved. After four more days of continued oliguria, less than 100 cc. of urinary output per 24 hours, and continued catabolic effect from the severely damaged left lower extremity, the clinical and chemical picture had

Table 1 (Case 1)

	First Dialysis 4/4/59		Second Dialysis 4/7/59		Third Dialysis 4/13/59	
	Before	After	Before	After	Before	After
Blood urea nitrogen	224.0	95.0	316.0	126.0	280.0	112.0
Carbon dioxide	13.0	24.0	14.0	23.6	14.0	22.7
Chloride	82.0	102.0	90.6	95.7	85.5	102.0
Potassium	6.4	5.1	6.9	5.4	5.2	5.0
Sodium	128.0	157.0	142.0	147.0	128.0	147.0
Calcium	7.8	11.0		11.3	6.4	11.8
Phosphorus	11.0	6.5		5.0	13.2	6.8
Creatinine	19.0	9.6	19.7	8.4	20.7	11.5
Uric acid			16.4	6.2	18.0	8.2

again deteriorated, and dialysis was repeated on April 7, again with improvement (table 1).

The urinary output began to increase somewhat following the second dialysis, up to 700 cc. in 24 hours, but on April 13 dialysis was again employed not only because of further chemical deterioration but because of severe pulmonary edema. The use of a cation exchange resin (sodium phase) four days before to combat a high serum potassium level may have contributed to this development. Digitalis, aminophylline, tourniquets, oxygen, and venesection were employed, but his condition remained critical until dialysis and ultrafiltration were performed. Cyanosis, dyspnea, and gallop rhythm subsided during the procedure. Increased digitalis effect was noted during dialysis as potassium was removed gradually and sodium and calcium restored to normal levels (table 1). Constant monitoring of the electrocardiogram during dialysis is very helpful. A first degree heart block which developed at the termination of dialysis responded immediately to 10 milliequivalents of potassium chloride intravenously. An estimated 4,000 cc. of fluid was removed.

During the postdialysis period of improvement, the left leg was amputated on April 15 after packing in ice. Urinary output continued to improve, and normal renal function gradually returned. The patient was discharged on July 10 after an additional surgical procedure, intramedullary fixation of the fractured femur.

Comment.—Hemodialysis here was employed for pronounced electrolyte derangement and metabolite retention in acute renal failure and for severe pulmonary edema. It concomitantly permitted the necessary surgical measures to minimize the severe catabolic effect.

Case 2.—A 52 year old white man was admitted elsewhere on May 1, 1959, with shortness of breath, cyanosis, generalized weakness, restlessness, and some confusion. The blood pressure was 140/90 mm. Hg, pulse rate 80, respirations 30, and temperature 99 F. orally. The chest was hyperresonant to percussion with the presence of sibilant and expiratory wheezes throughout both lung fields. There was no edema. At that time the fasting blood sugar was 105 mg. per hundred cubic centimeters, the carbon dioxide 7.5 milliequivalents per liter, and the nonprotein nitrogen 140 mg. per hundred cubic centimeters. The urine contained four to five white blood cells and 10 to 15 red blood cells per high power field. Specific gravity was 1.015. Three months prior to this admission he had been given three transfusions because of generalized weakness and anemia.

The patient became progressively more lethargic and acidotic. On May 13 he was transferred to Baptist Memorial Hospital in uremic coma and severe acidosis. There were inspiratory and expiratory wheezes throughout both lung fields. Dialysis was begun immediately on arrival and continued for six hours. The blood chemistry determinations before and after dialysis are shown in table 2.

Table 2 (Case 2)

	Dialysis 5/13/59	
	Before	After
Blood urea nitrogen	206.0	61.0
Carbon dioxide	13.2	21.3
Chloride	87.0	95.7
Potassium	3.5	4.0
Sodium	126.0	142.0
Calcium	7.8	10.8
Phosphorus	10.1	2.1
Creatinine	12.5	6.0
Uric acid	11.8	4.0

The pronounced Kussmaul respirations had subsided by the end of dialysis, and the next morning the patient was awake and able to speak. By the end of 36 hours following dialysis his sensorium had cleared completely. Continued clinical improvement followed, and he was discharged ambulatory on May 28 after receiving two units of fresh packed cells for anemia. Two months later the blood urea nitrogen had remained stabilized at around 66 mg. per hundred cubic centimeters, and clinical remission has continued to date.

Comment.—A “chemically sick” and apparently terminally ill patient responded dramatically to correction of electrolyte derangement and removal of metabolites by a single dialysis. Given this opportunity, his renal reserve was sufficient to permit a chemical readjustment at a level consistent with clinical remission. Furthermore, it should be pointed out that the clinical history here gave little clue to the nature or degree of reversibility of the renal disease present and dialysis has given additional time for further study and investigation.

Case 3.—A 51 year old white woman was admitted to Baptist Memorial Hospital on May 31, 1959, with a history of abdominal pain of one week's duration. She had been followed in the outpatient department for one and one-half years and was known to have chronic glomerulonephritis, hypertension, and congestive heart failure. She had had a previous admission for severe congestive failure and pulmonary edema. On admission, the blood pressure was 250/120 mm. Hg, hemoglobin

estimation 8.6 Gm., hematocrit reading 27.5, white blood cells 16,800 with a predominance of neutrophils, and blood urea nitrogen 72 mg. per hundred cubic centimeters. The diagnosis was subsiding acute diverticulitis, hypertensive cardiovascular disease, and acute exacerbation of chronic renal failure due to the intra-abdominal process. The last named was handled conservatively, and the tenderness and mass subsided progressively. Fluid and electrolyte management were difficult, however, because of persistent nausea and vomiting. On June 15 the blood urea nitrogen was 180 mg., chlorides 82 mg. per hundred cubic centimeters, and carbon dioxide 12.8, sodium 124, and potassium 4.6 milliequivalents per liter. With parenteral hypertonic saline and sodium lactate solution the sodium, chloride, and carbon dioxide levels were restored to normal. The urinary output had been maintained at around 3,000 cc. per day. The blood urea nitrogen, however, had continued to climb to 206 mg., and nausea and vomiting, weakness, lethargy, and somnolence became progressively worse. On June 25 hemodialysis was carried out with reduction of the blood urea nitrogen to 44 mg. (table 3). Five days later the blood urea nitrogen was 103 mg. Nevertheless, clinical improvement continued,

Table 3 (Case 3)

	Dialysis 6/25/59	
	Before	After
Blood urea nitrogen	212.0	44.0
Carbon dioxide	22.7	23.6
Chloride	87.2	102.6
Potassium	5.0	5.1
Sodium	130.00	140.0
Calcium	7.8	10.5
Phosphorous	11.9	4.1
Creatinine	12.8	5.0
Uric acid	10.6	3.2

the patient became ambulatory in her room, and appetite improved. She was discharged on July 4. A subsequent readmission two weeks later was necessary for severe anemia and anginal pain. She responded well to two units of packed cells. The blood urea nitrogen then was 75 mg., indicating recompensation to some degree of the renal failure.

Comment.—Because of the severe hypertensive cardiovascular disease, this patient was not an ideal candidate for prolonged remission following dialysis. The described improvement with a single dialysis was, however, most encouraging. Dialysis was employed here in an effort to “tide the patient over” the acute exacerbation of her chronic renal failure due to the intra-abdominal inflammatory process.

### Summary

The utilization of an artificial kidney is a practical therapeutic adjunct in a modern community hospital. Three cases are presented to illustrate the use of the artificial kidney in acute and chronic renal failure and in intractable pulmonary edema. The treatment of severe poisoning with barbiturates and other diffusible substances is stressed.

The Kolff coil kidney has rendered hemodialysis a technically feasible procedure for larger community hospitals everywhere. More and more

patients will be benefited by its wider use and increasing applicability.

Appreciation is expressed to James B. Strachan Jr., M.D. for his invaluable assistance in the care of the patients presented. Since this study was made, our experience has increased to 13 dialyses in eight patients. Our dialysis program was inaugurated in April 1959.

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# Intestinal Obstruction Due to *Ascaris Lumbricoides*

## *Report of Case*

HOWARD V. WEEMS, M.D.

SEBRING

A review of the literature on the subject would make one think that intestinal obstruction due to *Ascaris lumbricoides* frequently occurs in all climates, especially warm climates. Nevertheless, although I have been engaged in general practice and the practice of general surgery in a Florida town since 1922, this is the first case I have encountered. Fenger<sup>1</sup> recently stated: "In the Middle East, for example, statistical estimates of the prevalence of ascaris disease in the general population have run as high as 70 to 80 per cent. Similarly in China, the Philippines and some Caribbean countries, from 50 to 80 per cent of the people harbor this ubiquitous parasite to a greater or lesser degree. In the United States it is widespread, found in all parts of the nation, north and south, in hot or cold regions. Surveys indicate that in Kentucky, Louisiana, North Carolina and Southeastern Virginia, the incidence in adults is from 9 to 30 per cent, and as high as 60 per cent in children in rural areas."

In 1954, Jenkins and Beach<sup>2</sup> reported 31 cases of intestinal obstruction due to ascariasis. Interest in ascariasis is increasing because of emigration from the West Indies.

### Pathogenesis

Soil infested by ascarides and unsanitary living conditions are the main factors in the spread of the infection in man, but uncooked vegetables grown on polluted soil also carry the disease. The ova are swallowed and pass on to the small intestine; here the larvae emerge, pass through the intestinal wall into the lymphatics and small venules, and are carried to the right side of the heart and then to the lungs. The larvae migrate from the pulmonary capillaries into the air sacs, pass up the respiratory tract and are swallowed. In the small intestine they mature and mate, the time required from infection to adult worm being usually eight to 10 weeks. The larvae may enter the left side of the heart and be deposited as emboli in any blood vessel in the body.

Many persons harbor the worms in the small intestine with no clearly defined symptoms. There may be vague abdominal discomfort with occasional sharp colicky pains. Since the terminal ileum is a favorite site for the worms, appendicitis is often suspected. In fact, the worms may enter the lumen of the appendix and cause gangrene, or may penetrate the wall of the appendix and emerge in the free abdominal cavity. When the infestation is extensive, the patient usually becomes anemic, but may maintain a good appetite. The adult worms produce a toxin, ascaron, having varying effects, neurotoxic, anaphylactic, or hemolytic.

Complications are numerous and varied. Och-sner, DeBakey and Dixon,<sup>3</sup> discussing the complications of ascariasis which require surgical treatment, stated, "Since they are usually of a serious nature and offer a rather poor prognosis, it is imperative that the diagnosis be made early and treatment be promptly instituted." Any hollow organ may be obstructed, such as the trachea, intestine, and bile or pancreatic ducts. Volvulus or intussusception may occur without obstruction, but produced by ascarides. Other complications include appendicitis, intestinal perforation, hepatic abscess, lung and peritoneal granulomas, and lobular or lobar pneumonia. Larvae may be filtered out in the brain, spinal cord, spleen and kidney. Enterocolitis with diarrhea and melena is not infrequent.

### Report of Case

On June 13, 1958, a four year old Negro boy from Clewiston, Fla. was admitted to the hospital at Sebring, 75 miles distant from his home. The patient was only fairly well nourished. He was in pain of considerable degree; the abdomen was markedly distended, and there was no visible peristalsis. He had been vomiting frequently for two days. There was no history of previous episodes. On auscultation, the abdomen was silent. In spite of distention, one could palpate a sausage-shaped mass in the left lower quadrant of the abdomen. On examination of the blood, the red cell count was 3,450,000, the white cell count 9,400, and the hemoglobin estimation 62 percent. No roentgenograms were taken. A large size catheter was passed without difficulty, and a small amount of warm



water was instilled, which was partially returned with some red blood but no fecal matter. An enema the previous day gave similar results.

A preliminary diagnosis of intussusception was made, and an operation was performed. Before operation, decompression of the abdomen was begun with a Miller-Abbott tube. Under open drop ether anesthesia and while blood was being administered, the abdomen was opened by a left rectus incision, and a large amount of blood-tinged free fluid was suctioned off. The sausage-shaped mass previously palpated proved to be about 1.5 feet of small intestine so distended by a mass of intertwined ascarides that the intestinal wall was tissue paper thin and gangrenous in spots, and the mesenteric vessels showed fresh thrombi. Enterotomy afforded removal of more than 50 worms, but the color would not return to the overdistended intestine, and it was necessary to resect approximately 2 feet of small intestine. Sulfathiazole crystals were instilled, and end to end anastomosis was performed. The abdomen was closed without drainage.

Post-operative care included Wangensteen suction, intravenous glucose and antibiotics. Frequently, it was necessary to remove the suction tube because it became impacted with worms. No anthelmintic was administered until the patient was up and around the hospital and retaining food.

### Summary

In Highlands County in central Florida intestinal obstruction by ascarides was not known to have occurred previous to 1958.

Emigrant workers from the West Indies will probably cause an increase in the prevalence of ascaris infestation in this section.

In spite of statements by various authors that surgical treatment for intestinal obstruction by ascarides is not usually necessary, a case is presented in which, had conservative treatment been employed, the result would have been a fatality. Before operation, one cannot determine whether the intestinal wall has been so damaged by overdistention and pressure or by thrombi in the mesenteric vessels that it cannot have good blood supply after removal of the obstruction. Aiken and Dickman<sup>4</sup> recently commented appropriately, "Because of the danger of perforation, volvulus and strangulation and the increasing toxic effects of ascariasis, the surgeon should not temporize unduly when medical treatment is, or seems likely to be, ineffective."

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# The Use of Polysorbate 80-Choline-Inositol Complex in the Treatment Of Hypercholesteremia

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CORAL GABLES

Although the metabolism of serum cholesterol and other blood lipids has been investigated for many years, there still remains considerable controversy as to the relationship of serum cholesterol to complications of cardiovascular disease.<sup>1</sup>

It is known that the cholesterol content of the blood is governed by the balance which exists between the synthesis, utilization, absorption, destruction, and excretion.<sup>2</sup>

The elevation of serum cholesterol has been attributed to many factors. Although innumerable reports have been written on the apparent correlation of elevated cholesterol values to cardiovascular and other diseases, there is some disagreement as to the cause and effect relationship.<sup>1</sup>

In their study of 201 healthy families, Schaefer, Adlersberg, and Steinberg<sup>3</sup> showed that the average serum cholesterol values for men and women varied with age. The serum cholesterol values remained constant in men from two to 19 years of age, increased markedly from ages 19 to 23, and remained constant thereafter to age 60. In women, the values remained constant up to age 32 and then increased to age 58.

Sherber,<sup>4</sup> in his study of the relationship of serum cholesterol level to age in 2,046 patients, noted that there was a steady, almost linear increase in the mean values for serum cholesterol from the second through the eighth decade.

According to Gubner and Ungerleider,<sup>2</sup> any mechanism which elevates the fat content of the blood may result in elevation of the blood cholesterol. Among the commonest mechanisms are impaired removal of fatty acids by the liver, increased fat in the diet, decreased utilization associated with hypothyroidism, and mobilization of fat from fat stores. Also important may be the decreased capacity of blood to bind lipids with

proteins, and increased synthesis of cholesterol by the liver.

The treatment of patients who have hypercholesteremia varies considerably and many therapeutic agents, including lipotropic substances, thyroid extract, pancreatic and brain extracts, plant sterols, vitamins, estrogens, dietary measures, and polysorbate 80-choline-inositol complex, have been used.

## Method

A preliminary study was carried out to determine the efficacy of polysorbate 80-choline-inositol complex\* therapy in a series of private patients who had hypercholesteremia. Initially, serum cholesterol values were determined for six patients at monthly intervals. Within a short time, the serum cholesterol had decreased to such an extent that it was decided to extend the clinical evaluation.

The study was then expanded to include a total of 23 ambulatory outpatients, 39 to 79 years of age, who received polysorbate 80-choline-inositol complex therapy. The diagnoses made for these patients are presented in table 1. Nineteen of the 23 patients were men; four were women.

Polysorbate 80 complex, 10 cc. twice daily, was prescribed for 21 of the 23 patients. At the time therapy was instituted, 17 patients had serum cholesterol values greater than 300 mg. per 100 ml.; four had cholesterol values less than 300 mg. per 100 ml. The highest cholesterol value was 610 mg. per 100 ml.; the lowest was 235 mg. per 100 ml. For three of the 21 patients, the dose was halved during the course of the study (5 cc. instead of 10 cc. twice daily); one at the end of one month (D.L.), one at the end of seven months (L.T. -1), and one at the end of four

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\*Monichol—A complex consisting of polysorbate 80, 500 mg.; choline dihydrogen citrate, 500 mg.; and inositol, 250 mg. per 5 cc. Available from the Ives-Cameron Company, Philadelphia 1, Pa.





Patient	Age	Sex	Diagnosis	Therapy		Dose	Date	Cholesterol Value (mg./100ml.)
Cholesterol values greater than 300 mg. per 100 ml. at institution of therapy (cont.)								
H.D.	56	M	Essential hypertension, mild	Started 1/ 7/56	Stopped	10 cc. twice daily	1/ 5/56  3/ 2/56 7/ 5/56	320  224 230 Total reduction 90 314
H.McA.	50	M	Diverticulitis; essential hypertension, mild	10/ 8/55		10 cc. twice daily	10/ 7/55  12/ 6/55 1/26/56 4/ 5/56	320 307 275 Total reduction 39 290 330
F.P.R.	42	M	Slight obesity. Familial hypercholesteremia	11/ 3/55		10 cc. twice daily*	11/11/54 10/31/55  1/ 5/56	307 Total reduction 23 320
L.R.	48	M	Essential hypertension, mild. Familial hypercholesteremia	11/ 8/55		10 cc. twice daily	11/ 1/55  12/27/55 4/10/56	330 275 Total reduction 45 314
L.P.	49	M	Idiopathic hypercholesteremia	9/26/55		10 cc. twice daily	9/26/55  11/28/55 1/23/56 4/23/56	307 260 195 Total reduction 119 384
P.L.	62	M	Minimal generalized arteriosclerosis	10/ 4/55		10 cc. twice daily	10/ 3/55  11/ 3/55 12/ 6/55 4/ 3/56	422 350 275 Total reduction 109 610
J.H.R.	54	F	Arteriosclerotic heart disease with old and recent infarct	10/13/55		10 cc. twice daily	10/ 3/55  11/ 8/55 3/ 5/56	550 422 Total reduction 188

\* 50 per cent cooperation on treatment.

Patient	Age	Sex	Diagnosis	Started	Therapy	Stopped	Dose	Date	Cholesterol Value (mg./100ml.)
Cholesterol values greater than 300 mg. per 100 ml. at institution of therapy (cont.)									
G.M.K.	51	M	Idiopathic hypercholesteremia	9/26/55			10 cc. twice daily	9/19/55	360
								10/27/55	340
								1/ 5/56	290
								4/20/56	270
									Total reduction 90
L.T. -1	56	M	Arteriosclerotic heart disease with old infarct. Cholelithiasis	7/14/55			10 cc. twice daily	7/13/55	320
								7/15/55	314
								8/ 9/55	255
								9/ 2/55	275
								11/ 7/55	230
								2/ 9/56	185
									Total reduction 135
				2/10/56		2/10/56	5 cc. twice daily	7/ 9/56	314
									Total increase 129
D.L.	61	F	Generalized arteriosclerosis with old and recent cerebral vascular accident and old myocardial infarcts. Essential hypertension, moderate	9/22/55			10 cc. twice daily	9/15/55	330
				10/21/55		10/21/55	5 cc. twice daily	10/20/55	190
								11/21/55	272
				11/22/55		11/22/55	10 cc. twice daily		increase 82
								2/28/56	210
								6/ 5/56	175
									reduction 97
									Total reduction 155
Cholesterol values less than 300 mg. per 100 ml. at institution of therapy									
H.S.	38	M	Exogenous obesity	Low fat diet 12/10/54 to 9/30/55			10 cc. twice daily	12/ 9/54	320
								4/26/55	282
								9/29/55	275
								1/27/56	235
						3/ 6/56			Total reduction 40

Patient	Age	Sex	Diagnosis	Therapy	Dose	Date	Cholesterol Value (mg./100ml.)
Cholesterol values less than 300 mg. per 100 ml. at institution of therapy (cont.)							
O.G.R.	43	M	Familial hypercholesteremia	Started 11/ 8/55	10 cc. twice daily	11/12/54 11/ 4/55  1/10/56 4/11/56	307 290  282 185 Total reduction 105
L.T. -2	59	M	Arteriosclerotic heart disease with old infarct. Exogenous obesity	Low fat diet to 10/22/55 10/22/55	10 cc. twice daily	3/11/55 10/18/55  2/10/56	340 242 decrease 98  250
				3/ 1/56	5 cc. twice daily	6/29/56	300 increase 50
				7/19/56	10 cc. twice daily	1/ 1/57	230 decrease 70
J.C.F.	53	M	Exogenous obesity	On low fat diet and thyroid from 2/20/55 to 9/13/55 9/16/55	10 cc. twice daily	2/18/55 9/13/55  3/ 6/56	255 270 increase 15  242 decrease 28
Polysorbate 80 Complex not prescribed							
A.M.	51	M	Idiopathic hypercholesteremia	RIGID LOW FAT DIET		6/13/55 1/23/56 5/ 1/56 7/23/56	320 195 180 135 Total reduction 185
L.R.	51	M	Fatty metamorphosis of liver. Familial hypercholesteremia	RIGID LOW FAT DIET		11/ 9/54 10/28/55 5/ 1/56	235 270 195 Total reduction 40



months (L.T. -2). After one month and five months, respectively, on half of the prescribed medication, two patients (D.L. and L.T. -2) again were given 10 cc. twice daily.

Polysorbate 80 complex was not prescribed for two patients (L.R. and A.M.) who were maintained on rigid low fat diet therapy to determine their response to this alone. In one, the serum cholesterol was greater than 300 mg. per 100 ml.; in the other, it was less than 300.

A rigid low fat diet was not prescribed for any of the patients who were taking the polysorbate 80 complex. They were asked, however, to use vegetable fats whenever possible, cut gross fat from all meats, and limit the number of eggs to three to five a week and shell fish dinners to one every two weeks (because of sauces used therewith).

### Results

In this series, all patients given polysorbate 80 complex responded to medication. Nineteen of the 21 patients treated obtained favorable results; in two, the results were minimal.

Of the 17 patients who had cholesterol values greater than 300 mg. per 100 ml., 16 had marked reduction in their cholesterol values. The one patient in the group who had a minimal response to therapy had a cholesterol value of 330 mg. per 100 ml. before therapy and a cholesterol value of 307 mg. per 100 ml. at the cessation of therapy two months later. This patient admitted to taking only 50 per cent of the prescribed medication.

Of the four patients who had serum cholesterol levels less than 300 mg. per 100 ml., favorable results were obtained in three; and a minimal response was obtained in one.

The average reduction in cholesterol value for the 21 patients was 84 mg. per 100 ml. For the group, the reduction ranged from 23 to 188 mg. per 100 ml. The greatest reduction in serum cholesterol value in the shortest time interval was from 330 to 190 mg. per 100 ml. in one month (D.L.).

In three patients (L.T. -1, L.T. -2, and D.L.), there was a subsequent increase in the serum cholesterol value when the dose was halved (5 cc. twice daily). When the dose was again increased to 10 cc. twice daily (two patients, D.L. and L.T. -2), the serum cholesterol was again decreased, and these patients now have lowered or normal serum cholesterol values.

There was a decrease in the serum cholesterol value of the two patients (A.M. and L.R.) who

were able to adhere to rigid low fat diet therapy. The cholesterol values decreased from 320 to 135 mg. per 100 ml. in one (A.M.) in 13 months, and from 235 to 195 mg. per 100 ml. in the other (L.R.) in six months.

### Discussion

It has become increasingly apparent that there are many diseases which have hypercholesteremia as a common factor. Whether the presence of disease elevates the cholesterol or whether the elevated serum cholesterol is a forerunner of the disease is not definitely known. It has been stated that elevated cholesterol values usually are present in advance of coronary disease and are not necessarily the result of the disease.<sup>1</sup>

When large amounts of cholesterol are ingested by normal persons, no significant increases in the serum cholesterol levels occur.<sup>5</sup> It would appear, then, that an increase in the serum cholesterol value is the result of inadequate lipid metabolism.

It has been reported that there is a definite relationship between elevated serum cholesterol and the ingestion of fats.<sup>6</sup> When acceptable to patients, rigid low fat diet therapy may be effective in reducing the serum cholesterol.<sup>6</sup> Unfortunately, the patient must adhere to the diet for a prolonged period of time in order to obtain the degree of reduction required. This is difficult in that most patients will not adhere to a rigid diet for more than a few weeks or months. While caloric loss may be beneficial for the obese patient, a low fat diet with concomitant loss of weight may be disadvantageous for the thin or underweight patient.

Although the cholesterol values were decreased in the two patients in this study who were on rigid low fat diet therapy, it was necessary for one patient (L.R.) to adhere to the diet for six months in order to obtain a 40 mg. per 100 ml. reduction. The other patient (A.M.) required 13 months on a rigid diet to obtain a 185 mg. per 100 ml. reduction. My experience indicates that these patients could have achieved the same or better results in a shorter period of time on polysorbate 80-choline-inositol complex therapy.

Most of the patients in this study are still on polysorbate 80-choline-inositol complex therapy. To date, the use of this agent has resulted in a consistent and predictable lowering of the serum cholesterol in those patients who cooperated in taking the prescribed medication.

The serum cholesterol was markedly reduced in 16 of the 17 patients who had cholesterol values

greater than 300 mg. per 100 ml. There was a reduction in the serum cholesterol of the remaining patient in this group; however, it was not as great as would have been expected. This patient had not taken polysorbate 80 complex as prescribed.

One of the most important observations in this study was the necessity for maintaining a constant dose of 10 cc. twice daily. Reduction in dose or cessation of therapy resulted in prompt increase in serum cholesterol. On resumption of the regular dose, the cholesterol value again decreased.

The serum cholesterol was markedly reduced in three of the four patients who had control values less than 300 mg. per 100 ml. The remaining patient had a 28 mg. per 100 ml. reduction in the serum cholesterol. For a preceding period of seven months, this patient had not responded to low fat diet and thyroid therapy.

Although many of the patients reported subjective improvement, it cannot be stated specifically that the incidence of angina, biliary attacks, and so forth have been reduced. It appears that more vascular disease occurs in persons who have sustained hypercholesteremia. It remains to be seen whether or not the converse is true, that is, if there will be fewer disasters in those

who formerly had hypercholesteremia and now have a normal serum cholesterol value.

### Conclusions

Of the various agents and means proposed for reduction of serum cholesterol levels, polysorbate 80-choline-inositol complex in clinical practice appears to be the most practical in that it permits full cooperation on the part of the patient, and rigid low fat diet therapy is not required. The use of polysorbate 80-choline-inositol complex in the treatment of patients who have hypercholesteremia produces a consistent and predictable lowering of the serum cholesterol. It is essential that 4 teaspoonfuls (20 cc.) daily be prescribed for maximum response.

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# Bilateral Ectopic Pregnancy

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Schumann<sup>1</sup> estimated that extrauterine pregnancy occurs once in every 300 pregnancies. Bilateral simultaneous extrauterine pregnancy occurs less often and is considered the rarest form of double ovum twin pregnancies.

This study presents a case of bilateral ectopic pregnancy in which the second tubal gestation was found incidental to surgery for a ruptured ectopic gestation with acute intraperitoneal hemorrhage.

## Report of Case

A 30 year old, well developed Negro woman was admitted to the gynecologic service of Memorial Hospital at midnight on Sept. 20, 1956, complaining of nausea and diffuse pain in the lower portion of the abdomen that was more severe in the right lower quadrant. Her last normal menstrual period occurred on July 23. There was a small amount of brownish vaginal staining on August 20. Menses from September 16 to September 20 were slightly less than usual. The pain and nausea were only of one day's duration. She complained of urinary frequency, but no other subjective symptoms of pregnancy.

The patient was a gravida 0, para 0, who was treated with Combiotic for salpingitis on the left side in February 1955. The menarche began at 12 years of age and was of regular interval, lasting four days, with slight dysmenorrhea.

On admission, her temperature was 99.0 F., pulse rate 80, respirations 20, and blood pressure 110/80. On examination of the blood, the erythrocyte count was 2,420,000, the leukocyte count 17,400 with a shift to the left, the hematocrit reading 23.5 mm., the hemoglobin estimation 7.1 Gm., and the sedimentation rate 56 mm. Urinalysis showed specific gravity 1.019, pH 5.5, sugar 3 plus, albumin negative, acetone 4 plus and 40 to 60 white blood cell clumps.

Abdominal examination revealed slight tenderness in the right lower quadrant but no rigidity or rebound. Speculum and bimanual examination disclosed a bluish, soft cervix; the corpus was anterior, not enlarged, smooth, mobile, soft and slightly tender to motion. The left adnexal area was thickened. There was a right adnexal pulsating mass, tender and cystic in character. A diagnosis of unruptured right ectopic gestation and chronic pelvic inflammatory disease was made. The patient was scheduled for operation on the following morning.

At approximately 8 a.m. the next morning sharp pain suddenly developed in the right lower quadrant of the abdomen. The patient became restless and went into shock. She was rushed to the operating room.

At laparotomy, the abdomen was filled with at least 2,000 cc. of fresh blood. A ruptured right tubal gestation was found originating from the isthmus of the fallopian tube. Salpingectomy was performed on the right side since the right ovary was normal. Routine examination of the left fallopian tube revealed a fusiform swelling at the isthmus of the tube, measuring 2 by 1 cm. in size. The serosal surface was injected. An incision was made, through the tubal wall, into this mass, and a golden-brown granular material was extruded. It was thought that this was an unruptured tubal gestation. Salpingectomy was performed on the left side.

The postoperative course was uneventful, and the patient left the hospital in good condition. Microscopic study of the ruptured right tube revealed a chorionic sac and placental villi that were active. The tissue in the left tube showed a degenerated chorionic sac and placental villi that were undergoing degeneration.

It was concluded that the unruptured ectopic mass in the left fallopian tube was a gestation that anteceded the ruptured ectopic gestation on the right by approximately several days and that this was a double ovum twin pregnancy.

## Discussion

In 1939, Fishback<sup>2</sup> emphasized the necessity for positive criteria by pathologic examination for an acceptable case of bilateral ectopic pregnancy. These criteria include the presence of an embryo bilaterally, or in the absence of an embryo, chorionic villi must be identified by microscopic examination. Decidual reaction is insufficient evidence of ectopic pregnancy.

Stewart<sup>3</sup> reviewed a total of 212 cases of bilateral ectopic pregnancy. There were no distinguishing clinical features of bilateral ectopic pregnancy which were of value in the preoperative diagnosis. With the questionable exception of one case, the diagnosis was made at the time of operation. In most instances the preoperative diagnosis was pelvic inflammatory disease with tubo-ovarian masses, bilateral ovarian tumors, or unilateral ectopic pregnancy with acute intraperitoneal hemorrhage. The most consistent clinical features of diagnostic importance have been bilateral pelvic masses with a painstaking history of one or two episodes of acute intraperitoneal hemorrhage. There have been several instances in which bilateral rupture occurred simultaneously. The mortality of bilateral ectopic pregnancy is surprisingly as low as 3.6 per cent.

It has been repeatedly emphasized in the literature that both adnexa should be inspected when operation is performed for unilateral ectopic pregnancy.

With respect to therapy, the necessity for removal of both fallopian tubes is obvious. Plastic procedures may at times be considered on a portion of the better tube in expectation of future pregnancy. In young women especially, it is important not to sacrifice both ovaries when acute

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intraperitoneal hemorrhage is present. In such instances, surgery should be conservative.

### Summary

A case of bilateral ectopic pregnancy is reported. The salient features of this abnormality are discussed.

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## ABSTRACTS

**Superior Vena Cava Obstruction.** By M. Murray Schechter, M.D. *M. Times* 87:514-519 (April) 1959.

In this article a review is presented of the superior vena cava syndrome as caused by obstruction of the superior vena cava. The major manifestations of this syndrome include cyanosis and edema of the face, neck and upper extremities, markedly elevated venous pressure in the upper extremities with a normal venous pressure in the lower extremities, and distention of the superficial veins of the upper portion of the body with the flow being caudad. Almost all instances of obstruction of the superior vena cava by intrathoracic malignant tumors are caused by direct invasion of the venous wall by tumor tissue. A considerably decreased incidence of obstruction caused by aneurysms of the ascending aorta is now being observed. Technics for aiding in the diagnosis, localization and elaboration as to the nature of the obstruction are described. Because of the ability of veins to distend and enlarge without rupture, intracranial hemorrhage is relatively rare despite the increased pressure within the collateral veins.

The syndrome of superior vena cava obstruction is not as rare as was formerly believed; it should be searched for and studied more frequently. The author reports an incidence of 10 per cent involvement and obstruction in primary carcinoma of the lung. There is no place for surgical therapy in the treatment of the syndrome when it is due to infiltrative tumor. If radiotherapy or chemotherapy is used, it should be for its effect upon the primary tumor and secondarily to help preserve the collateral circulation. These forms of therapy will not relieve the obstruction when it is due to infiltration of the vein wall. Excision of a mass producing compression, such as an aneurysm,

gives relief of the syndrome unless secondary thrombosis has occurred. The effectiveness of therapy depends entirely upon the underlying disease process. Even though the venous obstruction may persist, the natural tendency is for the symptoms and most of the signs slowly to be relieved spontaneously by the formation of collaterals.

### The Chairless, One-Armed Pathologist.

By Alvan G. Foraker, M.D. *Am. J. Clin. Path.* 31:345-347 (April) 1959.

Strongly advocating the training of residents as physician-pathologists, the author of this article deplores a tendency in some medical schools to separate the "service" pathologists of the university hospitals from the "pure academic" pathologists who teach students and engage in research. He cites the several serious handicaps of this flight from reality and also cites certain personal handicaps suffered by the academic pathologist who has never acquired competence in surgical pathology and clinical pathology, or who has allowed these to languish. His conclusion is that the academic pathologist incapable of performing patient care functions has in part deprived himself of the status of physician. He has placed himself in the category of a non-M.D. basic scientist, and thereby suffers some disabilities. Research training and experience must be, in addition to achievement of professional competence in facets of pathology, important to clinical medicine. The young pathologist should not let his residency program and junior faculty appointments deprive him of training and experience in the practice of pathology. Otherwise, middle age and failure to achieve academic heights may find him "chairless and one-armed."

**Use of a Quantitative Electrocardiograph in Evaluation of Myocardial Contractility.**

By Robert H. Eich, M.D., Yale Citrin, M.D., Arthur Schreier, M.D., and Richard H. Lyons, M.D., with the technical assistance of Paul Gabel, B.S. *Am. J. M. Sc.* 234:631-639 (Dec.) 1957.

A modification of the calibrated electrocardiograph designed by Morgan and Sturm is described. It is believed that accurately calibrated records can be obtained with this instrument. A preliminary study of the motion of the border of the left ventricle is presented. An almost threefold variation in amplitude of border motion was observed among the normal subjects studied. The determinations in patients with heart diseases fell within the normal range.

Despite calibration, the actual border motion of the left ventricle has little meaning until similar quantitation of the chamber size can simultaneously be made in man. The calibration, however, permits the introduction of a "velocity index" which may reflect the true maximum velocity of the contraction of the myocardium. Normal subjects showed the expected marked increase in velocity in response to exercise. This was not true, however, in most patients with arteriosclerotic or hypertensive heart disease, or both, in borderline cardiac compensation. The results of this study suggest that the calibrated electrocardiograph may be a means of measuring myocardial contractility in vivo.

**Conference of Rehabilitation Centers (A REPORT).** By Nila Kirkpatrick Covalt, M.D. *South. M. J.* 51:1411-1416 (Nov.) 1958.

In this factual report, the author traces the development of the National Conference of Rehabilitation Centers, listing its most pertinent activities and policies. The growth of interest in rehabilitation has been remarkable. It is not surprising, the article points out, that the increase in centers has outstripped the supply of interested physicians and even the interest on the part of the medical profession. The profession, by training and experience, has not, as yet, had the vision of the teamwork needed in rehabilitation of the chronically ill or disabled patient. Dr. Covalt urges greater medical supervision and medical participation in the programs of rehabilitation centers.

She states that some of the future plans of the Conference of Rehabilitation Centers include

the employment of a full time, paid executive secretary, liaison with the National Association of Sheltered Workshops and Homebound Programs, consideration of means of satisfying architectural problems, and suggested steps to be taken toward standardization of nomenclature and accreditation.

Dr. Covalt states, "The Conference of Rehabilitation Centers is a sound organization, attempting, as are several other lay organizations, to offer medical services relating to rehabilitation, because those services are needed. Rehabilitation implies a multidisciplinary approach of which the physical portion and much of the psychologic is a medical problem. The insistence upon adequate amounts of medical supervision in every rehabilitation center must come from the medical profession itself."

**Pathology of the Dermatitis Produced by the Urticating Caterpillar, *Automeris io*.**

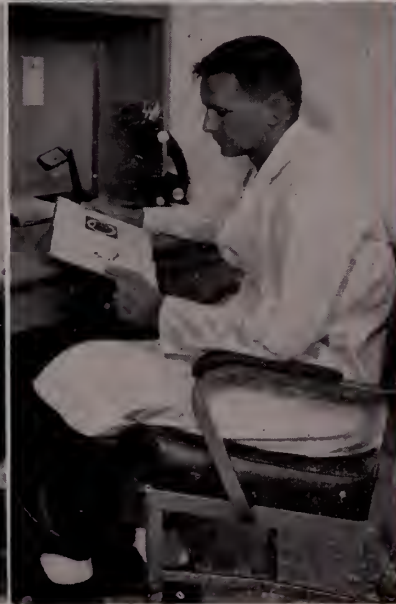
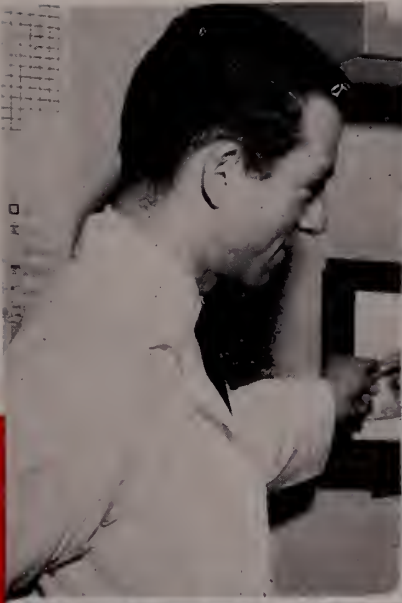
By David L. Jones, M.D., and Joseph H. Miller, Ph.D. *A. M. A. Arch. Dermat.* 79:81-85 (Jan.) 1959.

No reports of clinical or pathological studies were found by the authors concerning the lesion produced by the *Io* moth larva (*Automeris io*). The symptomatology is less severe and of shorter duration than that produced by contact with the puss caterpillar. Cases of venenation by the *Io* moth larva therefore probably do not often come to the attention of the physician. A heavy infestation of *A. io* on the grounds of a housing project in New Orleans prompted the investigation here reported.

In summary, the pathology of the dermatitis of the caterpillar of *Automeris io* is a rapidly developing edema of the corium and subcutaneous tissue without necrosis. The reaction is of approximately six hours' duration. The urticating substance was not analyzed. On clinical evidence, however, the reaction is compatible with one caused, at least in part, by histamine or a histamine release phenomenon. The poison apparatus of the caterpillar consists of venating hairs mounted on papillae. Each hair shaft is open to a poison gland in the papilla.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in *The Journal*. If you have no extra reprints, please lend us your copy of the journal containing the article.

# Medical Education in Florida





# Report for the Miami School of Medicine

HOMER F. MARSH, Ph.D., DEAN

CORAL GABLES

It is appropriate and the most important item perhaps to report that another class at the University of Miami School of Medicine completed the requirements for and its members were granted the M.D. degree in June 1959. This is the fourth class graduated since the beginning of the School and consisted of 58 members, all residents of Florida. This brings the total alumni to 177 members. In comparison to many of the older medical schools, a fourth commencement and total alumni of such small number are a far cry from any impressive statistics; yet the figures are indicative of a good start toward a long line of future classes and graduates.

The past academic year has been witness to activity having a direct beneficial impact on the School's future; yet there remain further problems for resolution to remind the faculty and administration that past accomplishment cannot suffice for future effort and continuing improvement. This report will encompass description of the basic activities and responsibilities of the School, including, wherever applicable, examples of the progress made toward a comprehensive center for medical education, service and research which has been visualized.

## Instructional and Training Programs

The basic responsibility of the faculty of any medical school lies in providing sound educational and training opportunities in medicine and its allied fields. Activities in the School of Medicine in Miami have included such opportunities for students working toward the M.D. degree, for those who have received this recognition and who are continuing their training in some specialty area, and for those who are interested in preparing themselves more thoroughly in the basic sciences of medicine by programs leading to advanced degrees in these sciences.

### Regular Medical Students

From the start of the School, it was planned to carry its regular classes at the level of 75 to 80 medical students. This class size was reached three years ago, and the new class for the 1959-1960 academic session includes 80 men and wom-

en. There is no plan to expand further the class size beyond this level within facilities available.

In keeping with the thought to offer opportunities to students from all parts of Florida, the four classes now in session include residents of 40 of the state's 67 counties. In the further thought that the School should be primarily responsible for the education of Florida residents, the number of nonresidents admitted has been held to the level of only five per class, actually less than the number permitted by the provisions of the state legislature. Thus, in the total student body of 275 regular medical students currently enrolled, 260 are residents of Florida and 15 are residents of other states. Distribution of the nonresidents is spread from California, New Mexico, and South Dakota in the West to Pennsylvania, New York, and New Jersey in the East and Georgia in the South.

### Legislative Action Affecting the School

The 1959 session of the state legislature took two actions which will have a salutary effect in the School.

One of these was in the area of financial assistance and directly related to the number of Florida residents in the student body. The incentive for establishing a school of medicine in 1952 was the promise of subsidy support from state funds in the amount of \$3,000 per year per Florida resident student enrolled. In toto, such support falls short of providing complete operational support for the School; yet it has been and is essential for the School's continuation, and does provide advantages to both the state and to the School. Near the close of the 1959 session, a bill was introduced and approved which increased the original subsidy from \$3,000 to \$3,500 per student per year. The increase which was provided for does not come into being at once, but affects only the incoming class during the first year, applies to two classes in the second year, and will apply to the four classes only at the beginning of the 1962-1963 academic year. Needless to say, this increase in operational income to an independent medical school is most welcome

and will go far toward stabilizing certain financial aspects of operation.

The second bit of legislation, even more directly concerned with students, was a more liberal definition of Florida residence as applied to applicants seeking admission. Under the initial legislation of 1951, 90 per cent of the members of any class were to be residents of the state, but for purposes of medical school admission these "residents" had to present proof of having been residents for at least seven years prior to admission. This restriction made for problems for the School and student alike. Bona fide applicants who had less than seven years of residence in Florida had to be considered as nonresidents. Many of these made application to other medical schools and had to be considered residents of Florida and could not be admitted to state-supported schools having residence restrictions to observe in selection of their students. Thus, Florida residents had no residence insofar as many medical schools were concerned. The situation was eased by an amendment to the existing legislation, and currently, Florida residence for purposes of admission to the University of Miami School of Medicine is the same as found in other institutions for higher learning in the state: legal residence. It is obvious this change will have the effect of permitting choice of students from among applicants,

and it is to be expected that more students of better qualification may be selected for admission.

#### **Graduate Students in the Basic Medical Sciences**

During the past four years, the preclinical departments of anatomy, microbiology, biochemistry, physiology, and pharmacology have offered graduate work to nonmedical students. In these programs, students were able to complete the Master of Science degree. Beginning with the current academic year, the University has instituted graduate work in several areas of the curriculum leading to the doctoral degree. Among the areas in which this level of graduate work was begun are the preclinical departments of the School of Medicine. In the present year, about 40 students working toward the Masters and doctoral degrees are enrolled in the preclinical departments.

#### **Graduate Students in the Specialty Fields**

When the School's first clinical teaching was started in its major clinical facility, Jackson Memorial Hospital, there were in operation several graduate training programs in the specialties. These came under the supervision of the faculty, and since 1954, the programs have been extended and expanded until now such training may be obtained in 17 of the specialty fields. Existing programs are approved, and two new ones are



Metropolitan Miami Medical Center: Left foreground, the new Medical Research Building, first wing of the permanent facilities of the School of Medicine; other buildings of Jackson Memorial Hospital, the primary clinical facilities of the School.



under development which are expected to be approved after they have been functioning for the required time.

Except for students in the regular medical curriculum, the number in the specialty training activities is the largest group in the School. There are 185 graduate physicians in these specialty programs.

The past academic year also marked the first time that "straight" internships were offered under the faculty's supervision. The Department of Medicine instituted a straight internship in internal medicine at the beginning of 1958-1959, and 12 physicians elected to carry this type of internship. These are in addition to the 60 interns in the regular rotating schedule.

#### **Reassessment of Financial Responsibility for Graduate House Staff**

When the School progressed to its first clinical teaching in the regular curriculum (1954), its faculty became responsible for intern and resident house staff training. At the same time, the University was required to assume full financial responsibility for stipends for the residents while the Jackson Memorial Hospital carried the payments to interns.

Discussions were begun about two years ago in an effort to reassess and reassign these financial responsibilities, and as a result, a new schedule was inaugurated July 1, 1959. Under this plan, the county (through Jackson Memorial Hospital) will continue to have financial responsibility for interns, and will also assume 75 per cent of the responsibility for the residents' stipends. The University will carry 25 per cent of the stipends for residents.

#### **Service to Patients**

It is impossible to separate service to patients from the educational and training efforts of the faculty. In the working agreement between the University (School of Medicine) and its teaching hospital the faculty is responsible for supervising and providing medical care for indigent patients of the hospital.

Inasmuch as Jackson Memorial is the county's major institution to which indigent patients can turn for medical care, the number of such patients available for clinical instruction is a rather large one. During the 1958-1959 academic year, this number ran between 17,000 and 18,000 inpatients, and about 50,000 clinic patients. The latter group accounted for approximately 250,000 patient visits

in the year. Despite the 1,000 beds in use at the teaching hospital, expansion has had to be made to accommodate the heavy demands of the county patients, and as a result of construction now almost complete, 1,400 beds will be used after January 1, 1960. As a result of this same construction program (financed by the freeholders of the county) a completely new emergency department was opened during the summer of 1959, an expansion of the outpatient department was accomplished, and a new mental health wing was added to the psychiatric unit of the hospital.

As these facilities come into operation, a greater number of patients become available for the School's teaching and training activities, and benefit from the work of the faculty.

#### **Research Activities**

A third area of activity expected from the faculty of a medical school is that of research. During the past decade, the volume of research being carried by faculties of the schools has reached the level of approximately \$87,000,000 to \$90,000,000 annually.

In the University of Miami, the extent of this activity has steadily increased until, during the 1958-1959 academic year, the total activity reached \$2,300,000 with just less than \$2,000,000 being operative at any particular time. This support came from many sources outside the University including federal and other governmental agencies, voluntary health agencies, foundations, industry, and individuals. Individual projects ranged in nature from very basic investigations to specific applied activities. As is to be expected, heavy support was given to projects involving various phases of the cancer problem, but research effort was not limited to cancer studies. Investigations into open heart surgery and other heart problems continued. During the year, an artificial kidney apparatus was obtained and put into use for research and service. An interdisciplinary correlation of effort in the investigations of the cause of aging was launched during the year. As a result of studies in the section of dermatology, involving the use of the antibiotic griseofulvin, it would appear that much headway has been made in the therapy of athlete's foot, an accomplishment which should make many sufferers grateful.

#### **Improvement of Research Facilities**

To date, research activities have been conducted in many areas of the community. The



lack of adequate and permanent physical plant to house the School's many-sided activities necessitated the utilization of temporary facilities in a scattered area. Such facilities have included remodelled barracks buildings at a former Navy installation, two warehouses in the neighborhood of the teaching hospital, and odds and ends of space in the hospital itself.

Construction was started a year ago on a new building to house research, and at this writing, it is expected that this construction will be completed by the end of October 1959. This building, partially financed through a construction grant from the U.S. Public Health Service which was matched by the County of Dade, will provide about 100,000 square feet of floor space for research. Unfortunately, during the time this building has been under construction, the volume of research activity has increased. Although the new building will provide welcome relief to certain crowded conditions, it will not permit the abandonment of the temporary facilities in use.

#### **Development of Improved Research Financing**

Funds to support almost every category of research interest are plentiful and easily obtained; yet the method by which such funds are allocated to investigators sometimes becomes quite time-consuming. Frequently, there are delays of several months between the filing of an application for research support and the granting of such request. At least one voluntary agency has tried to help this situation. The American Cancer Society makes certain "institutional grants" for research in cancer. The funds are made available to the institution with the provision that the exact application of such funds be the decision of a local institutional committee of the faculty. This arrangement permits the rapid activation of activity when a deserving request for assistance is made by a faculty member. Funds are readily available and are simply transferred from one account to another to make them available for a specific project.

The School was the recipient of such an institutional grant during the 1958-1959 academic year. Notice was recently received that the grant was renewed at an increased level for the current year.

In the same thought of providing ready research funds, uncategorized except as to the broad field of cancer, a group of women in the greater Miami area has organized as the Woman's Cancer Association of the University of Miami. This

group, numbering about 700, has as a sole objective the raising of funds to support cancer research in the School. Funds raised by this organization will be deposited in an account subject to the control of the same committee of the faculty which has controlled the institutional grant of the American Cancer Society. By having such a fund, there can be greater fluidity of support for research, and individual projects from the faculty can be put into operation with less delay than otherwise would be possible.

#### **Community Relationships**

A medical school does not stand alone in a community. As its several programs are certain to benefit the community in the long range picture, it should follow that the community should offer certain assistance to the School. Frequently this is done, but usually it is accomplished through official channels of the community government. In the hope that a section of the general public could be brought into the general situation of the School of Medicine, an organization was developed during the past academic year for which high hopes are held.

#### **Medical School Council**

After more than a year of consideration by the Executive Committee of the Faculty of the Medical School, a plan was submitted to the University Administration which provided for the organization of a group of business men and physicians who, it was hoped, would become more than casually interested in some of the problems of the Medical School. The University Board of Trustees approved such an organization which was formalized in January 1959. The organization, known as the Medical School Council, consists of 15 business men of the community and six physicians in the private practice of medicine. After a few preliminary meetings with the Dean of the School, and consideration of the types of problems in which the group might interest itself, the 21 man organization developed four broad areas of activity, each under the direction of a chairman who has a committee from the over-all Council. These committees are as follows: (1) Long Range Development, (2) Public Relations, (3) Physicians, and (4) Finance.

These committees have been active during the past months. In particular, the Finance Committee, after recognizing the urgent need of the School for permanent and more adequate physical plant, took on the responsibility of raising funds for the

construction of a medical education building. A campaign to raise the necessary funds is now under way. The Physicians Committee is interested in attempting to resolve certain long-standing differences of opinion which have existed between almost every medical school and organized medicine in greater or lesser degree. The Public Relations Committee has in mind the task of informing the general public of the activities and contributions of the Medical School, and the Long Range Development Committee will study the directions which may be taken in expansion and further development of the School. Taken as

a whole, it is hoped that the interests of this Council may eventually spread beyond the local situation, and its members may take an active interest in medical education throughout the United States.

#### **Postgraduate Offerings**

The School does not have a formally organized section of postgraduate education although, during the past year, several courses were offered to physicians by departments of the School. It is hoped that the current year will see a clarification of this most important aspect of activity and an inauguration of a substantial program.

# University of Florida College of Medicine

GEORGE T. HARRELL, M.D., DEAN  
GAINESVILLE

The opening of the University of Florida Teaching Hospital and Clinics on October 20, 1958 was a major landmark in the history of the school. The "tooling up" has entered its final phase with the development of the clinical curriculum and the teaching of fourth year students for the first time. The College of Medicine looks forward to the graduation of its first medical class next spring. The University has already graduated its first students from the J. Hillis Miller Health Center; three Ph.D. degrees in Medical Sciences were conferred at the June 1959 Commencement.

The University now enters a new period of service to physicians in the state in the use of these clinical facilities for the care of patients referred by family physicians throughout the area. Our postgraduate teaching program for house officers on the various clinical services has begun, and for the first time it has been possible to hold postgraduate seminars in our facilities.

The formal dedication for the Teaching Hospital and Clinics is scheduled for November 20 and 21, 1959. The Scientific Lecture will be given Friday evening by Dr. William Castle, the distinguished clinician who occupies the George Richards Minot Professorship of Medicine at Harvard University. The Dedicatory Address will be made Saturday morning by Honorable Lister Hill, United States Senator from Alabama, who has been so effective in promoting legislation to increase and improve health facilities in this country.

## Students

The fourth year class which will graduate in June 1960 contains 40 of the original 47 students, including all three of the women.

The third year class of 1961 will continue with 42 of the original 50 students, including the only woman. One student withdrew this year to enter graduate study of biochemistry in the College and one for personal reasons. One student received a Postsophomore Research Fellowship from the United States Public Health Service; he will work in the Department of Microbiology for one year after which he will continue his medical

studies. Five students withdrew because of scholastic difficulties; this rate of attrition is comparable with national experience. Carl W. Trygstad of Naples received the Roche Award as the student who at this stage of his development best exemplifies the ideals of the modern American physician—scholarship, character, personality, and seriousness of purpose.

Forty-five of the original 50 students in the class of 1962, including three of the women, are continuing into the second year. One woman and one man withdrew for personal reasons and three students for scholastic difficulty. Henry F. Curry Jr. of Orlando received the Stewart Thompson Memorial Award for scholastic performance during his first year.

The fourth class, which will graduate in 1963, was selected from 406 applicants. Of this number 132 were interviewed personally; 49 were admitted. The class includes four women who were selected from 18 applicants. The 47 Florida residents come from 18 counties in the state with the greatest number, five each, from Alachua, Dade, Duval, and Escambia. The College admitted its first Negro, a Phi Beta Kappa woman graduate of Fisk University whose home is in Orange County. One out-of-state student is from Ohio, and another is a resident alien from Cuba who has taken out his first citizenship papers. A bachelor's degree is held by 43 of the students, and one additional student has completed four years of college. Two students hold graduate degrees at doctorate level. Three students were elected to Phi Beta Kappa on the basis of scholastic performance in college. The class average for scores achieved on the nationally administered Medical College Admissions Test places the class in the upper half of all students in the nation. The range on each of the four parts is comparable to the scores of the three preceding classes. The national decline over the past few years in the number of top college graduates scholastically applying to medical schools has been a source of great concern to medical educators. The proportion of our students who enter with B averages on all college work has increased slightly over the past three years to 69 per cent.





The first patient admitted to the Teaching Hospital. This little girl from Williston was referred to the Pediatric Service. Two third year medical students and the Professor of Pediatrics are taking the history.

The students entering this fall come from 22 different colleges scattered over the country. Less than half of the students attended the University of Florida. This distribution represents a wider geographic spread in preprofessional preparation of Florida residents than in previous years. One third of the students are 22 years of age, the others ranging from 19 to 29. Nationwide older students are having increasing academic difficulty, and we have found this to be true in our other classes.

Selection has already begun for the 50 students in the Class of 1964 who will enter next fall.

The dissertations for the three Ph.D. degrees in Medical Sciences were: "Respiratory Effects of Carbonic Anhydrase Inhibition" (Physiology); "Ionic Basis of Postsynaptic Potentials in the Neuro-Muscular System of Lobster" (Physiology); "Measurement of Specific Reaction Rates Within Growing Cells" (Biochemistry).

One of these men is now Research Associate in the Department of Neurology, College of Physicians and Surgeons, Columbia University; another is doing research work at the Oak Ridge National Laboratory, while the third has a Post-doctoral Fellowship in the Department of Physiology here. At the present time five graduate students are enrolled in this program in the Department of Biochemistry, three in Physiology, and two in Anatomy.

The State Scholarships awarded annually through the State Board of Health have proved of tremendous financial assistance to medical students. Four of the recipients are in the Class of 1960, five in the Class of 1961, seven in the Class

of 1962, and three in the Class of 1963. Of these scholarships 15 were awarded for the entire four year period, three for three years, and one for two years. One student in the Class of 1961 dropped out during his second year, after holding a scholarship for a year and a half.

The proportion of entering medical students who are married remains about the same. The number in successive classes was 14, 18, 14, 16; these had respectively 9, 12, 14, 7 children. In the intervening years the number married has increased to 27, 26, 18 and the number of children to 18, 20, 16.

A large number of students continue to work in research laboratories of various faculty members informally to enrich their educational program. In the Class of 1960 four students were supported this year by summer research fellowships and seven by research grants. In the Class of 1961, 15 students have received fellowship awards and 10 are working as technicians or research assistants on grants. In the Class of 1962, 10 students received summer research fellowships and 12 are supported by research grants. The College is particularly grateful to the Florida Cancer Society, Florida Heart Association, Florida Tuberculosis and Health Association, and Broward, Palm Beach, and Volusia County Heart Associations which have awarded student research fellowships to increase the number granted by the National Institutes of Health, National Science Foundation and Lederle Laboratories. The value of this experience is shown by the fact that 11 scientific publications have resulted from student participation in research over the past three years. Even more important is the training which teaches the student to apply scientific methods of thinking to patient care in later years.

Financial support of medical students continues to be an increasingly pressing problem. The short term loan fund which has received contributions from members of the Florida Medical Association has been active in tiding students over acute emergencies. The William G. and Marie Selby Foundation of Sarasota has continued to make contributions each semester to the long term loan fund. We are grateful to the Woman's Auxiliaries of the Volusia, Bay and Manatee County Medical Societies and the Hillsborough County Medical Association for their contributions. These gifts have made it possible for us to increase the amount loaned from \$6,600 to 12 students in 1957-1958 to \$15,965 to 29 students

during the school year 1958-1959. Many more requests were received than could be met.

In addition to our own medical and graduate students, several very interesting educational experiments were conducted during the past summer. Graduate students from other colleges in the University, college graduates who had been admitted to medical school but who had not yet entered, undergraduate college students, and *high school* students have all worked in research laboratories. The National Science Foundation supported the high school students, one of whom had won fourth prize in the National Science Fair. These experiments have been conducted to stim-

ulate and recruit students, and to encourage improvement and enrichment of secondary and college courses.

### House Staff

The first house officers for the Teaching Hospital and Clinics reported during the summer and fall of 1958. The current house staff consists of 35 residents and 11 interns. These house officers are graduates of 23 different medical schools in 15 different states; three are foreign graduates; 24 are Florida residents who have taken their training to date out of the state. The house staff is distributed among the various clinical services



The front entrance of the hospital. Patients for the clinic and visitors to the hospital may unload under the wide canopy.



as follows: 12 in the Department of Medicine, six in Obstetrics and Gynecology, three in Pathology, six in Pediatrics, two in Psychiatry and 17 in Surgery. The house staff is expected to increase in size as the Teaching Hospital activates additional beds.

A generous gift has been made to the University to permit the establishment of the Charles J. Banta loan fund for house officers interested in further training for the care of crippled persons. The Lester R. Dragsted Loan Fund has been established for residents in Surgery. As inflation continues, the need for additional financial support for house officers and fellows is expected to increase in all clinical fields.

### Faculty

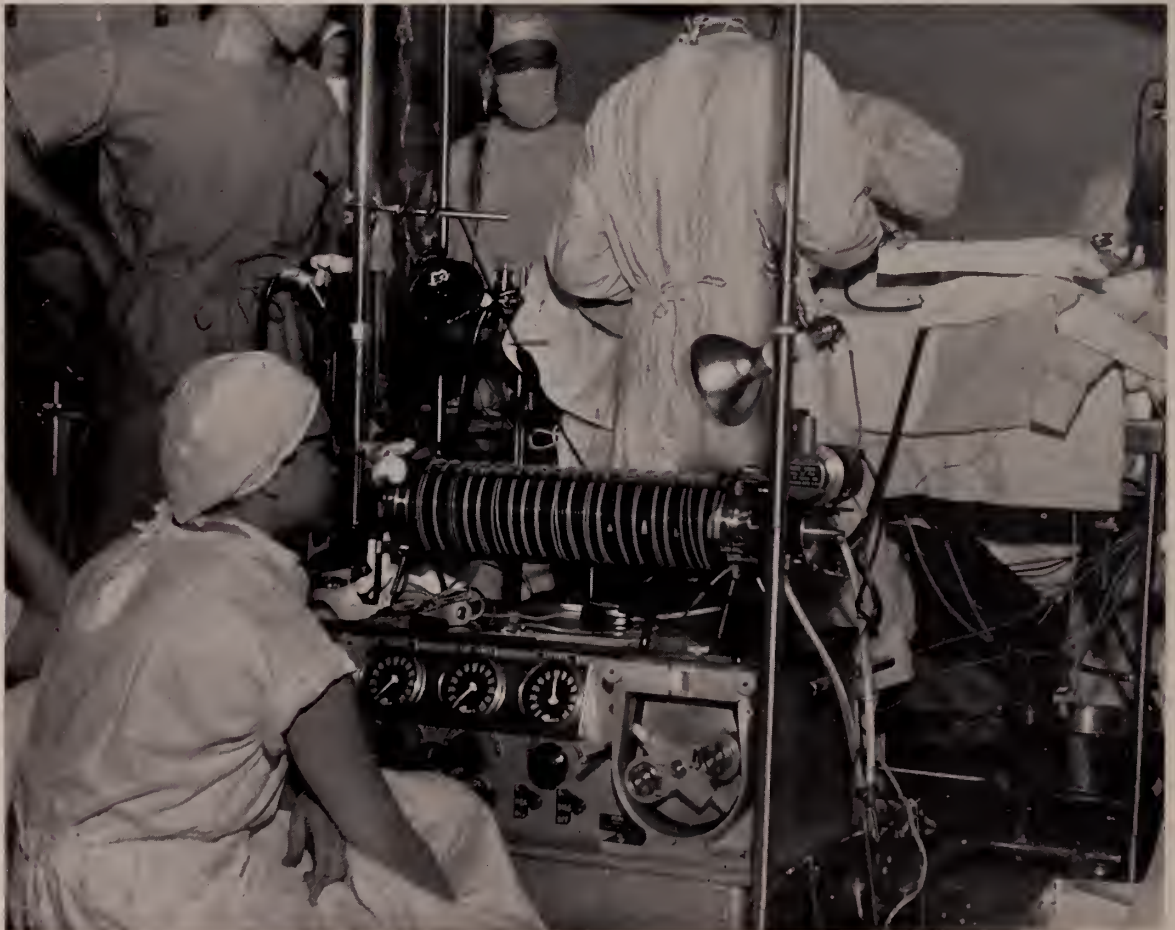
A few additions to the faculty for the basic science years have been made during the year. The faculty totaled 80 at the beginning of the current academic year. Three Senior Research Fellowships have been awarded by the United States Public Health Service, one each in Bio-

chemistry, Anatomy, and Microbiology.

The clinical departments are continuing the selection of faculty members in various fields. Members are being chosen on the basis of teaching ability and research potential. In addition to the full time faculty of whom 45 have M.D. degrees, 33 practicing physicians in the State of Florida from eight different cities are regularly serving as volunteer teachers in the clinical departments. The lectures, conferences, and consultations contributed by these physicians greatly add to the academic program and present in a practical fashion problems in the care of patients as observed in various communities in Florida. One basic science faculty member has resigned from a teaching post to return to full time research. The only other resignation since the school was established has been from a part time post in a clinical department.

### Physical Plant

The Teaching Hospital and Clinics had received most of its movable equipment when the



The artificial heart-lung machine in operation during open heart surgery for repair of a congenital defect.





The outpatient waiting room. The design incorporating a patio with a glass wall is intended to recall the Florida room of a home and to put a patient at ease.

first patients were received. Installation of equipment in the clinical diagnostic laboratories and in diagnostic and therapeutic Radiology is still continuing. The installation of equipment in the rehabilitation area of the clinics has been completed, and this unit began receiving patients in September.

The state highway (Route 24, the Archer Road) has been lowered and reworked as a four lane divided highway with a two lane service or access road in front of the hospital. The State Road Department has completed installation of signs on our site and on major highways outside of Gainesville indicating the most direct routes to the hospital. These signs have been of particular value for ambulances bringing patients to the emergency room. Two additional parking lanes in the east lot are under construction and should be completed in time for the dedication of the hospital.

The garden apartments were completed during the winter and are now occupied by married students in the third and fourth years of clinical training, house officers, and a limited number of technicians who are on call.

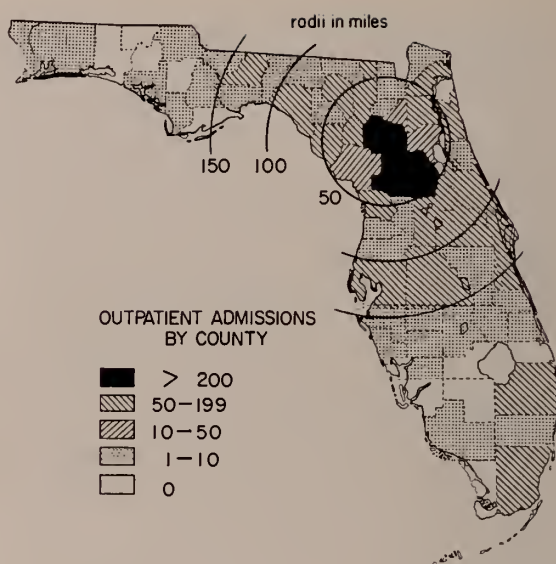
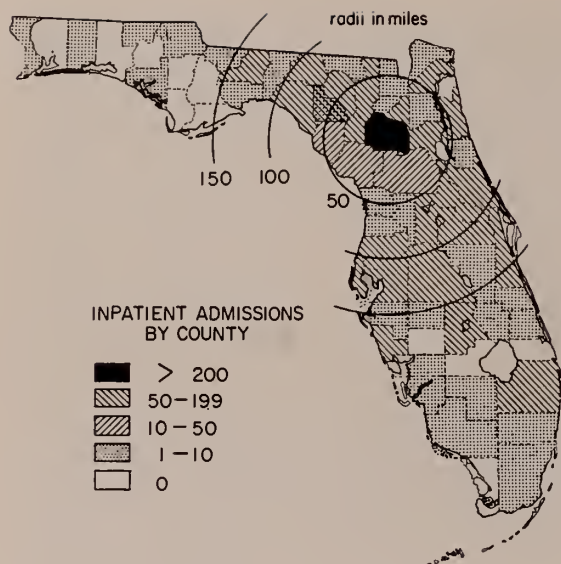
The Animal Farm listed last year as an urgent need was approved by the Cabinet, and construction should start this month. An appropriation by the legislature was matched by the United

States Public Health Service to provide funds for its construction. Land was donated by the College of Agriculture and Agricultural Extension Service from unused portions of the farm on campus.

A contract has been signed for the construction of the research wing to the Medical Sciences Building and for the wing for the College of Pharmacy. The necessary state funds were reapropriated by the 1959 legislature, and satisfactory bids were received in time to retain the construction grant from the United States Public Health Service. Completion of these facilities is scheduled for the summer of 1961 so that teaching in the College of Pharmacy will move to the Health Center site with the opening of the fall semester that year. The Research Wing will alleviate to some extent the lack of research laboratories now hampering full development of the program by the basic science departments. Only a limited amount of space in this wing will be available to the clinical departments.

#### **Clinical Services**

One floor of the hospital was opened October 20, 1958. As rapidly as staff could be trained, additional floors were activated. All clinical services are now in operation with one floor each devoted to Obstetrics, Medicine, Surgery, Pediatrics, and



Psychiatry. The sixth floor, which will be used for additional patients on Surgery and Gynecology, will be opened during the academic year in accordance with our plan to activate 50 additional beds each quarter. Occasional shortages in nursing personnel have been encountered as a result both of the general scarcity of nurses and of the curtailment of the budget by the legislature. As income from patients rises, this situation can be alleviated.

The ambulant concept has been enthusiastically accepted by patients who have been treated on the special ambulant wing. Some administrative details remain to be worked out with insurance companies and other third parties, but our hope that good medical care could be given cheaper than in the acute wing is being realized.

The number of patients seen in the emergency room continues steadily to rise. These patients furnish excellent teaching material for both house staff and students.

Patients referred for admission to the hospital have been of unusually high teaching value. A far greater proportion of patients than originally anticipated have been acutely or critically ill, a fact which has placed considerable strain on nursing service. We are particularly pleased that patients have been referred from all parts of the state as shown on the accompanying map. A number of patients have been referred from other states as far away as Washington and from outside of the United States as far as the Canal Zone.

Patients in the hospital have been well distributed between the different services during the 10 months of operation. The Medical Service

has admitted the greatest number of patients. On one occasion in the early fall the one ward open for the Surgical Service was completely full. The number of patients admitted by the Department of Obstetrics and Gynecology has exceeded our expectations, and this is the third most active service. The Pediatric Service has shown steady growth, and both it and the Psychiatric Service have been operating at capacity for the number of available trained personnel. As had been anticipated, admissions have been relatively heavy in certain specialties such as Neurology, Neurosurgery and Orthopedics.

The General Clinic is receiving by referral adequate numbers of patients for clinical teaching and is now meeting each afternoon at 1 p.m. Monday through Friday. The steadily increasing patient load has necessitated the opening earlier than expected of a number of specialty clinics. Patients are being referred from all parts of the state to the Outpatient Department, as shown in the accompanying map.

It is apparent that the predicted radius of 125 miles from which patients would be referred is a realistic one, and the maps indicate that distances up to 150 miles are reasonable both for inpatients and outpatients. It is anticipated that these patterns of referral will not change greatly during the coming year.

Patients for admission to the hospital or clinics must be referred by the family physician. The patient who is acutely ill and should be admitted directly to the ward may be referred by telephone (FRanklin 2-3411) to the Chief of the appropriate clinical service or to an individual physician



on the staff; a letter should follow. Most other patients may be referred by letter to the Chief of the General Clinic or to a particular doctor in the Diagnostic Clinic. All patients are seen by appointment, and prior arrangement will facilitate prompt examination.

The legislature has required by law that the hospital and clinics be as nearly self-supporting as possible. Payment for hospital charges should be arranged in advance through Blue Cross or other insurance, the indigent hospitalization program, or other resources.

The faculty continues to meet with the Liaison Committee of the Alachua County Medical Society to discuss mutual problems. These meetings help promptly to clear up misunderstandings.

### Research

An active research program is in progress. On September 1, 1959, 74 different research grants were in operation to support specific projects. The total of the grants in force for this year is \$621,492. Support for research has come from voluntary health agencies in Florida both at state and county level, the Armed Services and national voluntary agencies and foundations as well as various federal agencies. Several unrestricted grants from industry have been continued.

Students are increasingly active in research projects. One student has been in England obtaining additional training. One medical student completed his thesis during 1957 and received his Ph.D. in Psychology. Our students have presented several research papers at national scientific meetings.

The number of publications resulting from work done at Gainesville has steadily increased. During the past year scientific papers have been read by the faculty in Canada, South America, and Europe including some countries behind the Iron Curtain, as well as in this country.

Research cannot be expanded further until more space is available. The additional laboratories in the research wing will not be available until the fall of 1961.

The first research professor has been appointed, Dr. Lester R. Dragsted, who will work with house officers and students in the Department of Surgery.

Faculty members from medical schools abroad continue to come to obtain training in specific research technics or to engage in particular projects. A member of the Department of Anatomy



An outpatient examining room. The front part is decorated to resemble a living room in a home. The curtain is pulled while the history is taken so that the patient will not be distracted by furnishings which would remind him of a hospital.



A room in the ambulant wing. The day beds, television, telephone, pictures and drapes have been chosen to create the atmosphere of a home rather than of a hospital. A member of the family may stay with the patient during treatment in this wing.

of Charring Cross Medical School in London spent several months working on a problem involving Florida porpoises, for instance.

Postdoctoral Fellows from Japan and Sweden are in residence receiving additional research training. The first postdoctoral trainee who has gone out as a full time permanent faculty member has joined the Department of Anatomy at the University of British Columbia.

### Curriculum

The College of Medicine is continuing its university-wide interest in preprofessional preparation. Members of both the Basic Science and Clinical faculties are serving as counselors for undergraduate students in the general education



program in University College as well as in the preprofessional advisement panels in the College of Arts and Sciences. Faculty members are teaching freshman courses in Biology and sophomore courses in Logic as well as more specialized courses such as one in the College of Business Administration on interpersonal relations. Members of the faculty have given lectures or seminars in areas of the humanities such as English as well as in the physical sciences. The exchange of faculty with other areas in the University is now beginning to flow in both directions. Members of the Colleges of Arts and Sciences, Education, and Agriculture have taught portions of our courses in Biochemistry and Physiology as well as introductory courses which cover genetics, growth, development, and variability.

Adjustments and refinements continue to be made in the curriculum in the first and second years. The introductory courses in Medicine mentioned and those which include the development of personality, social patterns and other facets of the normal individual are being intensively studied. Patients at the Sunland Training Center as well as pupils in the University laboratory school are being used to introduce first year students to clinical material early in their educational experiences. The course in Experimental Medicine at the end of the second year is being used as a bridge between the application of the scientific method to the basic sciences and its use as a tool in clinical medicine; all departments participate in the course.

The initial clinical experience in the third year is a basic clerkship on the hospital wards. Patients are intensively studied from the broadest possible point of view regardless of the floor of the hospital or service to which they may have been admitted. The teaching is done with groups of instructors from various clinical disciplines. The major part of the third year is spent in the General Clinic. In this educational experience the student sees the patient under conditions which simulate his office in the community where he will see the majority of his patients. The approach again is the broadest possible study of a limited number of patients so that the student will learn to think in terms not only of the disease process but also of the individual as a member of society in his home community and the impact of the illness on the family. These broad approaches are planned to train family physicians for practice in Florida. In the General Clinic consultations are

held by members of all clinical departments serving as broadly trained physicians without relation to their special areas of clinical competence. Cross Consultants are used in their capacity as specialists to insure optimum patient care and to teach the student to think and study in depth.

In the fourth year students will serve inpatient clerkships on particular services and will work in special outpatient clinics. During the fourth year one quarter of the time is reserved for electives which are offered by both clinical and basic science departments. During the past summer students were permitted to take electives in special fields outside of Gainesville. For example, several students worked in Jacksonville at the Duval Medical Center under the Executive Director of Postgraduate Education and the immediate close supervision of the clinical staff.

A scholarship convocation has been held annually. This year the well known Florida physician and author, Dr. Frank G. Slaughter, will lecture on "The Physician's Heritage." These cultural exercises supplement the scientific lectures and seminars given by other visitors frequently throughout the year.

#### **Postgraduate**

The faculty continues to participate in postgraduate programs both on the campus at Gainesville and elsewhere in the area. A progress report in more detail will be found in this issue of *The Journal* on page 590.

Physicians are invited to clinical conferences conducted by the faculty. Grand Rounds are held Saturday from 8:00 to 9:00 a.m. and are followed by Clinical-Pathological Conferences from 9:00 to 10:00 a.m. and the conference on Clinical Pathology from 10:30 to 11:30 a.m. Other conferences are held in the afternoons as follows: Monday, 4:00 p.m., General Clinic, 4:30 p.m., Hematology, or Infectious Disease on alternate weeks; Tuesday, 4:00 p.m., General Clinic, 5:00 p.m., Neurology and Neurosurgery; Wednesday, 4:00 p.m., Endocrinology, 5:00 p.m., Surgical Pathology; Thursday, 4:30 p.m., Cardiology; Friday, 4:00 p.m., General Clinic, 4:30 p.m., Chest.

#### **Nursing**

The enrollment in the College of Nursing continues to increase rapidly. A much closer correlation between the educational and service programs is being achieved through an administrative adjustment in the College. Members of the

faculty teach the practice of nursing through actual patient care on the wards of the hospital.

### **Other Services**

The College of Health Related Services received its first students for training this fall. The faculty is using teaching facilities in the Medical Sciences Building and Teaching Hospital for Physical Therapy, Occupational Therapy, Medical Technology, and Vocational Rehabilitation counseling.

### **Needs**

Additional financial support for medical students is urgently needed. The long term loan fund continues to receive contributions as previously mentioned, but more funds are needed now before students start to repay after they enter practice. A start has been made on a loan fund for house officers, but the contributions so far have been restricted to particular services. The summer research fellowships have proved of great value to students; this program could be extended, both in number and duration of the fellowships. The state scholarships are of great help to the limited number of students who receive them. Other scholarships, particularly some which can be awarded on intellectual attainment and merit alone, should be obtained.

A critical need continues for an increased supply of superior students. Recruitment should begin at high school level so that a long range educational program can be properly planned for the student. Physicians in the state should continue strongly to support the recent moves which are already showing results for improvement in the teaching of science, as well as other subjects in the high schools.

Additional academic personnel are needed particularly in the clinical departments. All available space for these departments is now in use, so that it will be necessary to double up in offices and research laboratories until more space can be provided.

An outdoor play area for children should be constructed on the roof of the connecting wing between the Teaching Hospital and Medical Sciences Building. The rehabilitation of children

could be speeded up, and the morale of patients confined in the hospital for long periods by chronic illness could be greatly improved if they could be taken out of doors for exercise and sun.

An outdoor rehabilitation area should be provided so that the transition from the somewhat artificial situation in the inpatient rehabilitation area to practical living situations in the community can be made more smoothly. Space is available at ground level adjacent to the indoor facilities which could readily be converted to various types of walks, steps and functional activities found in the home and yard.

Another parking lot will be needed to the west of the outpatient clinics as our patient load increases.

The steady growth of the library will necessitate additional stack space within one to two years.

The growth of clinical departments, the inauguration of clinical research programs and the requests from physicians for highly specialized studies will require more space. A clinical research wing could be built to the east of the present Medical Sciences Building and will be badly needed within the next few years. It will be impossible to increase the present size of classes without additional faculty members and space in which to house them.

The interest shown by medical students, house officers and practicing physicians in the teaching program in the Department of Radiology indicates that much larger space must be provided for Radiology conferences.

The unfinished areas in the delivery, operating room, and radiology suites should be completed for the special purposes for which they have been planned.

### **Future**

We are moving steadily toward the development of a program of education and patient care integrated with the University as a part of an over-all state educational system. The College of Medicine and other units of the Health Center are training physicians and other health personnel at all levels for practice in Florida and the region.

# Postgraduate Medical Education At the University of Florida 1959-1960

WILLIAM C. THOMAS JR., M.D., DIRECTOR  
GAINESVILLE

Activation of the teaching hospital and an increase in the number of clinical faculty at the College of Medicine of the University of Florida have permitted the planning of a more comprehensive program of postgraduate medical education during the coming academic year than was heretofore possible. In developing this program it has seemed wisest to plan short seminars devoted to particular subjects in the various clinical specialties. It is hoped that this scheme will permit presentation and discussion of topics in a thorough and meaningful manner.

During this year five seminars are planned in different clinical specialties, and each is to be of two and a half days' duration as indicated in the accompanying schedule. These seminars are to be so constituted as to be of practical import to the physician whether he be a specialist or a general practitioner with particular interests. The subject matter will consist of lectures, discussion groups, and presentation of patients, all designed to present to the physician recent developments in the respective fields. New knowledge in the basic sciences which has application to the management and understanding of disease will also be presented. Active participation by those attending these seminars has proved valuable and stimulating and is encouraged. The recent seminar in Neurology on September 24-26 was most instructive and was attended by 70 physicians from various parts of the state.

It is planned that each of the seminars mentioned will be conducted annually. Other programs

designed to meet the wishes and needs of practicing physicians will also be developed. It is anticipated that a series of seminars in Anesthesiology, in Psychiatry, and in Radiology will be inaugurated beginning in the 1960-1961 academic year. Moreover, the office of postgraduate medical education is prepared to organize seminars on any subjects deemed advisable by the physicians of Florida and suggestions are welcomed.

The faculty for these conferences will consist of invited authorities in the particular specialties in addition to members of the staff of the College of Medicine of the University of Florida. Detailed programs including application forms for individual seminars will be mailed to all physicians in Florida approximately two months prior to the respective meeting, and advance registration is necessary. There is a fee of \$25 for each seminar, but interns and residents are exempt from this charge.

In addition to the program outlined all physicians are welcome to attend both the clinical conference and clinical-pathological conference held each Saturday morning between 8 a.m. and 10:30 a.m. in the Hospital Amphitheatre. Interested physicians are also invited to the regular clinical conferences in the various specialties held throughout the week at the Medical College. Special arrangements for physicians who might desire more lengthy or intensive training in particular clinical or basic science disciplines may be provided on an individual basis. A schedule of the weekly clinical conferences and currently planned seminars follows.

### Clinical Conference Schedule

Monday	4:30 p.m.	Hematology-alternating with Infectious Disease	Hospital Amphitheatre
	5:00 p.m.	Orthopedic-Anatomy	M-220
Tuesday	8:00 a.m.	X-ray	A-254
	4:30 p.m.	Neurosurgery-Neurology	Hospital Amphitheatre
Wednesday	8:00 a.m.	X-ray	A-254
	4:00 p.m.	Endocrinology	Hospital Amphitheatre
	5:00 p.m.	Surgical-Pathological	M-623



Thursday	8:00 a.m.	X-ray	A-254
	8:00 a.m.	Pediatric	Hospital Amphitheatre
	4:00 p.m.	Cardiology	Hospital Amphitheatre
Friday	8:00 a.m.	X-ray	A-254
	4:00 p.m.	Chest	Hospital Amphitheatre
Saturday	8:00 a.m.	Clinical-Pathological	Hospital Amphitheatre
	9:00 a.m.	Grand Rounds	Hospital Amphitheatre
	10:00 a.m.	Obstetrics-Gynecology	Hospital Amphitheatre

**Medical Seminars\***

Neurology	September 24-26, 1959
Surgery	January 14-16, 1960
Physical Medicine	January 28-29, 1960
Pediatrics	February 11-13, 1960
Obstetrics and Gynecology	February 25-27, 1960

\*Approved for credit by the American Academy of General Practice.

**DO YOU HAVE . . .**

**A PAPER – FILM – OR SCIENTIFIC EXHIBIT**

You would like to present at the Florida Medical Association's Eighty-Sixth Annual Meeting, April 8-11, 1960, Jacksonville?

Scientific Paper—An abstract of 50 words  
should accompany application

Film—Short description with application

Exhibit—With application, send resume of  
subject and photograph or sketch

**DO YOU HAVE . . .**

**A HOBBY OR COLLECTION?**

An innovation this year is the exhibition of Florida physician's hobbies and collections. Prepare your exhibit and notify us promptly of the space you will need.

Remember: All applications must be submitted by November 15.

To be assured a place on the program, contact

**THAD MOSELEY, M.D., *Chairman***

Committee on Scientific Work

P. O. Box 2411

Jacksonville 3, Florida

## Florida Medical Foundation

Since assuming the office of President of the Florida Medical Association, I have been impressed with the fact that many doctors are not adequately familiar with the Florida Medical Foundation. This is in spite of the fact that a brochure from the Foundation has been sent to every member and in The Journal of the Florida Medical Association there have been several accounts of the formation and progress of the Foundation. Since this organization is, in a sense, part of the Association, it seemed worth while for me to bring this activity to your attention again.

At the annual meeting of the House of Delegates in 1956, the Foundation was created. It met with enthusiastic approval, and the interest was such that spontaneous pledges for contributions were made from the floor of the House.

After obtaining the Charter, the Foundation proceeded to operate in a limited manner because of the fact that tax exemptions for contributions would not be allowed until the corporation had been in existence for a year. In January 1959, the tax status was established by the government so that all contributions are exempt from income tax.

So far there have been several types of contributions and contributors. Illustrations are as follows: The Marion County Medical Society made a contribution which was not assigned to any specific purpose. The Dade County Medical Association established a Medical Student Loan Fund to be administered by the Foundation. The Duval County Medical Society gave funds for aiding indigent physicians. Individuals have sent through the Foundation contributions to specified medical schools, and donations have also been made to specified hospitals. Other contributions have been made to be used at the discretion of the Foundation.

From these examples, it is obvious that the objectives of the Foundation are being followed. Let me repeat these objectives:

1. Improvement of the health and of the medical care of the people of Florida.
2. Sponsorship of graduate and postgraduate medical education.
3. The aid of persons of Florida needing financial charitable assistance who are pursuing an education in medicine.
4. The aid of deserving indigent or destitute physicians who by reason of illness, mental or physical incapacity need charitable assistance.
5. The promotion and sponsorship of medical research exclusively for public purposes and benefits.

In order to get authoritative advice in the matter of sponsorship for medical research, representatives of the Foundation have met with members of the faculties of our two Florida medical schools. This conference clearly showed that although there are already many sources providing funds for medical research, none of these solve the problem of the need for immediate support of worthy projects wherein the element of time is important. In other words, both schools have had experience in not being able to promote challenging projects because it takes too long to secure support of agencies other than the Foundation. This obstacle would be especially great to a doctor who, independent of a research organization, was qualified to do research.

The Board of Governors of the Florida Medical Association has complete responsibility of and authority over the funds of the Foundation. Its members are the ones who decide how the unassigned contributions are used. Obviously, these doctors have the point of view of the members of our Association and will represent effectively their wishes.

It is my hope that the members of the Florida Medical Association will show increasing interest in our Foundation, that they will seek information about it, and that they will make comments and criticisms as they desire.



# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## Indigent Care for the Indigent

Perhaps the biggest hindrance to the solution of any new problem is the use of old ideas and methods. To launch a satellite called for new approaches to new concepts. In scientific research, the term of heretic or radical is not used to describe a worker who attempts an unorthodox approach to a problem. In the social sciences, a nonconformist or dreamer is labeled an egghead. In medicine, a new approach, if it deals with a professional problem, is welcomed, but unfortunately when a different concept is applied to the various parameters other than treatment, the bold venturer is practically excommunicated from most of organized medicine's circles.

For centuries, the poor have always been treated by physicians without pay. It had been accepted that part of a physician's duty was to see that no one should go without treatment. Today, one of the major problems of organized medicine is the care of the indigent. Our orthodox procedure has been the use of charity clinics and free hospitalization for the poor. The only remuneration expected from the charity patients was that they allow themselves to be used for teaching purposes. Of course the fact that the indigent patient might have to wait in a crowded clinic

for eight or more hours before being seen by a physician for 60 seconds did not seem to matter too much. If the charity wards of some hospitals were populated with rats, bold and big enough to bite some decrepit individual, this situation might evoke brief newspaper comment. If, because of the inability to obtain elective treatment, a wage earner became a dependent, one more on the dole would not matter. The physician true to his code would eventually treat the indigent and heal him if possible, even though the physician were tired and exhausted from his own practice in which 15 per cent of his patients were charity patients.

We, as physicians, being conservative men, would probably continue on our Don Quixotic way of caring for the poor, but this is the age of the common man. No longer may the feudal baron give scraps to his serf to eat. No longer may the plantation owner care for his slaves with paternalistic if meager fare. This is the age in which another war may be fought to preserve the dignity of man. It is therefore apparent that the philosophy which called upon physicians to treat the indigent without charge has been discarded.

The good physician must temper rapid change



with some degree of conservatism, but if he were to submit to no change, he would still be using leeches and letting blood. Even our medical schools are in a state of flux, re-examining and changing their methods of teaching more radically than at any time since the twentieth century began.

It is thus apparent that we, as physicians, must stop our anachronistic attitude of trying to solve a twentieth century problem with a medieval philosophy. We can no longer use the argument that it was good enough for our fathers and hence, it is good enough for us. Our social philosophy now holds that the basic concept of life and the pursuit of happiness also includes health. As physicians we can no longer remain aloof and disdain anything that smells of social change. What the public wants, eventually the public will get, with or without our help. We must stop nurturing the immature hope that 200,000 physicians are going to stop any social change though some of our number believe that because we as physicians will not accept social security benefits, all those now receiving them will magically not want theirs and that our nonparticipation will strengthen our fight against socialized medicine. Socialized medicine will come when the majority of the public is dissatisfied with the medical care they receive and with the price they pay for it.

We physicians have given up our ideas of humors and the supernatural. We no longer use amulets or potions. We should realize the follow-

ing facts and use a fresh approach to the problem of care for the indigent;

Basically the average American does not want charity. Being a charity patient does not fit the dignity of an American.

Under our present setup, there will always be patients who will not be cared for.

The young physician has not been imbued with the traditions of giving free service to the indigent any more than the grocer gives free food or the clothier free apparel.

With rare exception, the physician who receives pay for his services will do a better job. Perhaps the old adage that something for nothing is worth what one pays for it has an excellent application here.

This is no appeal for socialized medicine. It is merely an appeal to wake up to the fact that our present problem in caring for the indigent cannot be answered with our present methods. We must re-evaluate the problem and use new approaches. Our failure to do so would truly be a travesty on our American ideals and beliefs. If we do not change voluntarily, the change which will be foisted upon us will not answer the problem as well and will not be the American way of freedom of choice. Let us break the shackles and remove the blinders. Let us call upon the past for experience, but not for antiquated methods to solve a new and difficult problem. Let not our care for the indigent be indigent care.

J. J. L.

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### **Tentative Schedule Announced for Scientific Assemblies 1960 Annual Meeting**

Following the meeting of representatives of the special interest groups, the Board of Governors of the Florida Medical Association, and members of the Association's Committee on Scientific Work, September 13, at the Hotel Robert Meyer in Jacksonville, the tentative schedule for the first and third scientific assemblies has been determined.

At the first scientific assembly on Saturday, April 8, to discuss "Recent Developments in Treatment of Infections," speakers will be sponsored by the Florida Chapter, American College of Chest Physicians, the Florida Academy of General Practice, the Florida Society of Dermatology, and the Florida Pediatric Society, in cooperation with the Florida Medical Association.

On Monday, April 11, at the third scientific assembly to discuss "Management of Acute Trauma," speakers will be sponsored by the Florida Society of Plastic and Reconstructive Surgery, the Florida Chapter, American College of Surgeons, the Florida Orthopedic Society, and the Florida Neurosurgical Society, in conjunction with the Florida Medical Association.

Each of these speakers will be the invited guest of the special interest group with the understanding that he will participate in discussions before the Association's scientific assemblies and the special interest group. His expenses will be shared on a predetermined basis by the two organizations. His entertainment will be the responsibility of the sponsoring special interest group.

## Pneumonia — 1959

Although pneumonia is no longer "captain of the men of death," it warrants re-evaluation from time to time. The existing therapeutic armamentarium can make its management simple and gratifying or confused and unsound with the harmful effects of medication outweighing any beneficial results. Indeed, certain types of pneumonia are engendered by therapy aimed at other types of the infection.

Careful consideration of the etiology of the pneumonia in the individual patient is essential for well planned therapy. A division into bacterial and viral ("presumed," "atypical," "bronchopneumonia X," et cetera) furnishes a simple working arrangement.

Bacterial pneumonias are in general characterized by a sudden onset, high fever, signs of consolidation, and brisk leukocytosis. Obvious exceptions exist, such as elderly and debilitated patients in whom none of these features may be present. Alcoholics frequently have a profound leukopenia, a poor prognostic sign. Of the causative agents of bacterial pneumonias, the pneumococci, staphylococci and *Klebsiella* (Friedländer) organisms are most frequently encountered.

Staphylococcic pneumonia occurs most often in the very young and aged. It oftentimes is an accompaniment of viral infections of the respiratory tract, particularly influenza. During an epidemic such as the recent one caused by the "Asian strain" of the virus, the number of cases of staphylococcic pneumonia rises sharply, and mortality may be excessive. The staphylococcus produces a patchy pneumonia which may be confluent. The sputum is often blood-tinged. In infants and young children a rapidly developing empyema often occurs. This pneumonia should be treated with bactericidal agents such as massive doses of penicillin in combination with erythromycin. Other antistaphylococcal agents may be used. Prompt determination of the sensitivity of the isolated organism will help in the accurate management. Defervescence and resolution may be slow.

Friedländer pneumonia characteristically occurs in debilitated or alcoholic patients. It is not generally appreciated, however, that it can affect otherwise young and vigorous persons. The mucoid, stringy sputum mixed with bright red blood

is characteristic though not universal. The roentgenogram which shows a bulging interlobar fissure is suggestive of Friedländer's pneumonia. Streptomycin in combination with chloramphenicol or one of the tetracycline compounds is preferred by most.

Pneumococcic pneumonia, the classical "lobar pneumonia," is usually an "all or none" disease. Its varied clinical picture, however, in the elderly, in the diabetic, and in the alcoholic, must be reckoned with. Penicillin remains the drug of choice. In this day of astronomically high doses of this agent, it is well to recall that the first cures recorded involved a total of 40,000 units. In patients sensitive to this agent, any of the currently available antibiotics may be used. There is no indication for a combination of drugs in uncomplicated pneumococcic pneumonia. With all bacterial pneumonias one must be on the alert for the development of atelectasis, particularly in those unable to raise sputum adequately. Altered flora resulting from antibiotic therapy can result in perplexing superinfection with resistant microorganisms.

It should be apparent that the proper management of the patient with any of the bacterial pneumonias depends on prompt and accurate identification of the offending organisms. At least one blood culture should be drawn on any such patient, and a careful study of the sputum undertaken. The extra time required for collection of a good "cough specimen" is more than rewarding. The patient must be encouraged to cough deeply and raise material from the lungs. Saliva is not adequate. The gross characteristics and odor give some clues. A gram stain must be done on the sputum promptly. A predominance of lancet-shaped gram-positive diplococci, or clusters of gram-positive cocci, or short, fat gram-negative bacilli surrounded by a large capsule strongly suggests pneumococcic, staphylococcic, or Friedländer pneumonia respectively. The sputum culture will be confirmatory, but at least 12 hours of valuable therapeutic time can be saved by the careful study of the stained fresh sputum.

"Unresolved pneumonia," be it of these etiologies or "mixed," demands a careful search for underlying disease, especially carcinoma. An acute lung abscess can present with all the fea-



tures of a classic bacterial pneumonia. A history of aspiration is helpful in this differentiation.

The viral pneumonias present a varied and complex clinical picture. A gradual onset, malaise, fever, a hacking nonproductive cough, a low white blood cell count and a paucity of physical signs are the usual features. An acute onset, however, with chill signs and consolidation may occur, or there may be only mild "grippelike" symptoms with infiltrates noted only in roentgenograms.

Most sporadic cases defy exact etiologic diagnosis. Some strains of adenovirus have been shown to cause pneumonia in infants and in military personnel. The psittacosis-ornithosis viruses can produce the clinical picture of atypical pneumonia and are to be suspected whenever there is contact with birds, particularly parakeets. Q

fever, caused by *Coxiella burnetii*, evokes similar clinical features, but its existence in this part of the country has not been proved. Therapy of the viral pneumonias is difficult to assess. Milder forms should be treated symptomatically. In the more severe forms, it is prudent to administer one of the "broad-spectrum" antibiotics, preferably one of the tetracycline group.

The physician should ask himself "What is causing this pneumonia?" and take appropriate steps to answer the question. He will find that administration of the precise antimicrobial agent(s) usually results in a gratifying response, devoid of the risks and further diagnostic dilemmas common to "shot-gun" ill-planned medication.

MAX MICHAEL JR., M.D.

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## Coordinated Program for 1960 Annual Meeting Jacksonville, April 8-11

On Sept. 13, 1959 in Jacksonville at the Hotel Robert Meyer, Dr. Ralph W. Jack, President of the Florida Medical Association, presided at a meeting of the Association's Board of Governors, its Committee on Scientific Work and representatives of 18 of the 21 special interest groups organized in the state. At this meeting, the problems of the special interest groups as they are related to the Association were discussed in a healthy atmosphere which cleared many previously existing misunderstandings.

The Committee on Scientific Work presented a program format and requested the coordination of speaker use by the special interest groups and the Association. Realizing that in past years excellent speakers had presented addresses before special interest groups with minimal previous advertisement of their presence and at times embarrassingly small attendance, the Board of Governors and the Committee on Scientific Work believe that by the coordinated use of these speakers the scientific caliber of the Annual Meeting will improve and the members will have maximum opportunity to hear these speakers.

To make it easier for the general membership of the Association to attend the Annual Meeting, the week end will now be utilized with the meeting starting Friday noon, April 8, 1960, and continuing through Monday afternoon, April 11. It

is believed that physicians in private practice will have an easier time being away from their home and practice during these week-end days and it is hoped that this shift of dates will increase the number of physicians in attendance.

The plan to shift meeting dates and to coordinate the use of speakers was presented before the representatives of the special interest groups and was unanimously approved by all.

It was therefore decided that the first scientific session will be held on Saturday morning and that the treatment of infections will be the subject of the papers presented at this session. The speakers on this program will be shared by the special interest groups and the Association. The second scientific session will be held on Saturday afternoon immediately following the President's presentation of his guest speaker. This session the Committee hopes to devote to the presentation of papers on medical problems peculiar to Florida. The third scientific session will be held on Monday morning, and the program will again be presented by speakers to be shared with the special interest groups. The treatment of acute trauma will be the subject under discussion at this session. On Saturday morning and Monday morning, following the presentation of the specific papers, there is planned a one hour panel discussion of the general fields to be covered by these papers.



As in the past, Sunday will be devoted to the special interest group business meetings and scientific presentations. The Committee requested the special interest groups which are to share speakers with the Association to hold their business meetings on Sunday morning, completing those meetings before 10:30 a.m., and also requested that the Committee be allowed to make an effort to coordinate the scientific program presentation of the shared guest speakers before the special interest groups so that as many physicians as possible may hear each speaker in his chosen field. This suggestion was also acted upon favorably,

and an effort will be made to achieve this coordination at the 1960 meeting.

The meeting of September 13 demonstrated what can be achieved when a mutual understanding of the problems is reached. The Committee hopes that in future years such a meeting may be held annually in an effort to solve the many difficulties.

PLAN TO ATTEND THE 1960 ANNUAL MEETING AT THE HOTELS ROBERT MEYER AND GEORGE WASHINGTON, JACKSONVILLE, APRIL 8-11.

THAD MOSELEY, M.D., CHAIRMAN  
COMMITTEE ON SCIENTIFIC WORK

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## An Impression of Moscow Medicine

EMMET F. FERGUSON JR., M.D.  
JACKSONVILLE

The American Exhibition in Moscow and the Moscow Chamber of Commerce invited a delegation from the Jacksonville Chamber of Commerce to Moscow to witness the showing of "The Jacksonville Story" at the exhibition there. I was fortunate to be a member of the delegation, and was privileged while there to visit several Russian hospitals in the Moscow area. Upon discussing the visitation with Dr. Edward Jelks, I was asked by him to write down some of my impressions.

My impression of Moscow medicine can be presented in the three phases in which I saw it, namely, visits to (1) a general clinic, (2) a large clinical hospital, and (3) a medical institute.

### The General Clinic

The first day was spent in the general clinic. Mrs. Finagine, my interpreter; Mrs. Ernberger, a U. S. Public Health nurse, and I met Dr. Sinukova, the head doctor at the clinic, and held a general discussion while sipping Russian tea. She explained that there were 95 physicians assigned to the institution, that they serviced 50,000 patients within a radius of 900 meters, approximately one-half mile, that they had five machines (cars) for the group and that they were paid approximately 800 rubles a month. Incidentally, it is difficult to assay the value of a ruble. On the international exchange, four rubles equal one dollar; a visitor in Moscow gets 10 rubles to the dollar. While in Paris, I was offered 60 rubles to the dollar. One cannot take rubles in or out of

the Soviet Union without violating the blackmarket laws. The planned Soviet economy makes the assessment doubly hard. The price of an automobile may equal the price of 25 to 50 pairs of shoes.

All of the doctors that we met in the general clinic were women. In fact 65 to 75 per cent of the doctors in the Soviet Union are women. I was led to believe that this percentage was due to the concept that medicine is a less strenuous occupation and therefore better adapted for women. This, however, is incongruous with the fact that invariably we saw women doing all sorts of heavy work from ditch digging to baggage loading. Perhaps a more adequate explanation lies in the shortage of men between the ages of 30 and 45. Russia lost 12 million men in World War II. Then too, bright young men seek the higher prestige jobs of engineering and mechanics.

Nevertheless, these doctors seemed to have it pretty easy. They worked six hours a day, three hours making house calls and three hours in the clinic. One half hour was subtracted from the six and accumulated for an eight hour night duty which fell their lot one or two nights a month.

These "800 rubles a month" doctors were fairly well versed in the management of minor medical ills, preventive medicine, and Marxian doctrine. Their education consisted of 10 years of grade school and six years of medical school. Mrs. Ernberger, a United States Public Health nurse,

who spoke fluent Russian and was a valuable aid to me in our visitation, observed that the Russian doctors in this particular stratum were about the equivalent of our public health nurses and visiting nurses in the States.

We discussed many facets of medicine. Dr. Sinukova said in our conversation about preventive medicine that malaria, plague, venereal disease and tuberculosis were well controlled. She attributed the decline in venereal disease to sociologic forces rather than to antibiotics. She used penicillin, Terramycin and streptomycin, but had never heard of Chloromycetin, Albamycin, Erythrocine, et cetera. Prostitution virtually has ceased to exist, she related, since under Marxism the monetary incentive has been removed. Salk vaccine was available, but not widely used. Doctors were waiting for a more effective oral type of polio vaccine which would be available soon. Work was being done on vaccines for undulant fever, Mediterranean anemia and mumps. During the past several years influenza epidemics have ceased because of a preparation which is inoculated by applying to the nasal mucosa an attenuated influenza organism, about 15,000,000 being inoculated yearly. In the treatment of tuberculosis, the drug Galanthamine, an alkaloid, is used and allegedly is very effective.

My thoughts were somewhat churned when I asked her, "Do you have many neurotics?" "No, they belong to the capitalistic way of life," she replied with an air of conviction. "In our society we have controlled the economic factor which produces the tensions, conflicts, and anxieties of yours." We pursued this discussion for a while, but I have long since learned not to argue with a person about his politics or religion. I did, however, gain the impression that the Russian doctors do not give much credence to Freud and, in fact, think that he was a "quack." They believe more in economic and materialistic factors as producers of conflicts, rather than the subconscious and spiritual factors. Dr. Sinukova condemned the use of electric shock and prefrontal lobotomy. As for the psychotics, she admitted that they had their share of schizophrenics, but like American doctors had no cure. Psychotherapy is as confusing to them as it is to us. Pavlovian concepts of conditioned reflexes dominate their thoughts in this field.

After leaving her office, we took a tour around her hospital. I noticed a typical diaphragm for contraceptive use. I also noticed a little metal

cap that we used to use over the cervix for the same purpose, and commented that we had given this up since it predisposed to cancer. She immediately countered by saying that they did not leave it on that long. Seemingly, the patient desiring birth control is brought in on the twelfth day of the menstrual cycle, the cup is then placed in position, and on the eighteenth day it is removed. I told her this procedure appeared to necessitate many visits. She said, "We have plenty of time."

We discussed abortions. They were performed in this clinic if the patient desired them, but in general they were discouraged. I gathered that the patient had to pay a fee or a fine to have an abortion, about \$15 to \$25. The doctors had no moral compunction about performing abortion so long as the patient presented herself before the third month.

At this same general clinic, many babies were delivered. The doctors used no anesthetic, but all the patients were given antepartum a special course in "Child Birth Without Fear," based on a book by Read (an Englishman). Fairly elaborate clinical facilities were set up for this instruction.

The minor surgery room was not elaborately equipped. There were, however, excellent physiotherapy and ophthalmologic facilities.

Dr. Sinukova, the hospital chief and our most cordial hostess, had been in this one clinic for 22 years. Her top salary was 1,500 rubles a month. As we left after an enjoyable and pleasant visit, I gave her an American ball point pencil, and she in turn gave me a Russian book.

### **The Large Clinical Hospital**

The next day we visited the 2,300 bed Bottkin Hospital, one of the largest clinical hospitals in Moscow, and were received by Professor Shabanov, the chief doctor. Here the medicine practiced dealt with the more acute and complex cases. Bottkin Hospital was composed of many individual units, covered about 23 acres, and reminded me of the old Grady Hospital in Atlanta. It was originally built in 1910, ironically for a communistic hospital, through the beneficence of a wealthy merchant who left two million rubles to build a hospital for the poor. The Professor said that it originally was a 400 bed hospital, but now in this period of "Soviet power" it was a 2,300 bed hospital. He stated that its primary purpose was treating, training, and research. There were 365 doctors, 900 medical nurses, and 1,400 practi-



cal and laboratory workers. They treated 40,000 patients a year and performed 10,000 operations. Approximately 2,000 doctors come yearly for six month periods of time for training and qualifications. Central heating was used, and the fuel was gas. The over-all budget was 42 million rubles a year.

My interpreter and I spent several hours with Professor Shabanov. He was not only the chief surgeon but also the top administrative official at Bottkin, and I judged from some of our conversation about his recent visit to Peiping, China, that he was rather high up in the communist hierarchy.

There seemed to me to be a great difference between this professor and the "800 rubles a month" doctors whom I met in the clinic the day before. He was poised, sure of himself, and possessed considerable clinical knowledge. There was no doubt that his prestige, social standing and income exceeded many fold that of the general clinic doctor. We discussed appendicitis, infections, cancer, trauma, peptic ulcer and gallbladder disease. His mortality from appendicitis was 0.3 per cent. He stated that gynecologic operations were the operations most frequently performed, but that 30 to 35 per cent of the surgery there was gallbladder surgery. We both jokingly, but I think quite rightly, attributed the high incidence of gallbladder disease to the heavy greasy diet of the Russian people. As for infections, he had noticed no particular increase such as our staphylococcal increase. Cancer of the liver was of interest to him in that he had recently given a paper before the Moscow Academy on the subject. Out of 3,500 cases of gallbladder disease treated surgically he had found cancer of the liver in 120 cases. Apparently, cancer of the stomach is the chief cancer in men, representing 25 to 30 per cent. Professor Shabanov reported an increase in cancer of the lung, about 20 per cent of all cancer in men, and correlated this with smoking much as we do. At this point he offered me a Russian cigarette which really does have a recessed filter. The filter comprises three fourths of the cigarette. As for cancer in women, both cancer of the breast and cancer of the cervix rank neck and neck, about 25 per cent each, much the same as our own percentages.

I was particularly surprised to learn of my host's knowledge of American medical literature. We discussed it under the subject of peptic ulcer, posterior gastroenterostomy and vagotomy, hemi-

gastrectomy and vagotomy, and Wangensteen resection, and he was quite conversant. He said he still preferred a 70 to 75 per cent resection with a Billroth II type of anastomosis for complicated peptic ulcer. Surprisingly enough, the Russians subscribe to about 1,800 American scientific and medical journals and these are abstracted usually within the month, much more rapidly than our nine months' to a year's delay.

Before making the tour around the hospital, Professor Shabanov asked me to be objective in my picture taking as well as in my impressions. Once he failed to let me photograph an open ward; yet later when we came into a ward where there was hospitalized a recently injured American, he let me photograph him in order that I might send a picture to the American's family. As would be expected, the first thing the American said to me, after the Professor introduced us, was, "Get me out of here, Doc." I saw in the same room with the American a patient who had had a lobectomy two days before under local anesthesia and was apparently doing well.

We toured the remainder of the hospital with Assistant Professor Medridousky. He showed us the ambulance, which looked exactly like one of our Packards, but it was built in Russia and not by Packard. Then we went to the operating room where we watched gallbladder, appendix and thyroid surgery being carried out under local anesthesia. The technic was fairly good. In performing the appendectomy, the surgeon injected about a quart of 0.25 per cent Novocain in the abdominal wall. When he made the incision, fluid, not blood, oozed from the wound. I asked him about hyaluronidase, but he was not familiar with its use. The appendix—you guessed it—chronic appendicitis. The surgeon had on his gown over his street clothing, the masks fitted poorly, the windows were open, and an electric fan was playing directly on the wound. Again I asked about his infection rate, and again he assured me that it really was not a problem.

Bottkin Hospital was the institution in which Lenin was operated on in 1923. I am certain that in this country if George Washington, Abraham Lincoln, Franklin Roosevelt or Dwight Eisenhower had been operated on in a similar institution, a new modern hospital would have risen on the spot. Russian clinical medicine is substandard as compared with our own. The doctors are seven to 10 years behind us in the clinical application of medicine. This lag is probably the



result of a priority system of controlled economy which puts Sputniks No. 1 and hospitals way down the line.

Upon leaving, I gave Professor Shabanov an American Boy Scout knife for his grandson. He seemed to appreciate it and in turn gave me a book for my daughters.

### **The Medical Institute**

Our next visit was to a medical institute, the Chest Institute, located at the First City Hospital. The institute is the epitome of Soviet Medicine. There are some 70 such institutions in the City of Moscow. These institutes are the more specialized medical centers, and it is here that the Soviets spend a great deal of money on research, both experimental and clinical. There is an institute for all the various forms of surgery, medicine, neurology and the like. Here at the Chest Institute the chief emphasis was placed on lung, breast and heart surgery. There were clinical and experimental departments, the latter being housed in an older building; however, another more modern building was in the planning stage. Professor Rovnov, my host, explained his hospital setup. The fourth floor was a cardiological diagnostic department. The third floor was devoted to surgical cardiology, one half of which was concerned with correction of congenital abnormalities and the other half with the correction of adult degenerative cardiovascular conditions. The second floor was devoted to pulmonary surgery; here, also, one section was set aside for tumors of the lung and the other for pulmonary infectious processes other than tuberculosis. Tuberculous patients were treated in another institute. The first floor was divided into two sections, one for diseases of the esophagus and breast, and one for the urgent surgery such as stab wounds. Interestingly enough, acute coronary infarctions were also treated in the urgent surgery department.

Dr. Rovnov further explained that he had departments of laboratory, x-ray, angiocardiology, electrocardiography, biochemistry, bacteriology, and, in fact, a total of 15 laboratories similar to our own in the States.

He continued by saying that the staff doctors began work at 8:30 a.m., and gathered in a conference at 8:45 a.m., at which time the physician having the previous night's duty oriented everyone for about 15 to 20 minutes. The doctors then went to operating rooms. They operate five days a week and on Saturday morning hold a con-

ference in which they discussed the previous week's interesting cases, as well as the plan for the next week.

The Professor was proud of his institute, saying that it was supplied with the most up-to-date equipment and doctors of good qualification. He emphasized that not only were patients treated here, but a large part of the institute's function was to train surgeons from remote parts of the Soviet Union for three to six months each in breast surgery. If the trainee showed interest in surgery of the heart, lung and esophagus, the staff surgeons shared their experiences with him.

He said that in this institute special attention was paid to anesthesia. It seems that it is customary there to use a combination of narcosis and local anesthesia. The Professor stated that he had just about decided that an esophagectomy was too much surgery for local anesthesia and he preferred narcosis. Upon asking him why the doctors use so much local anesthesia in Russia, he replied, "It is safer. Perhaps, also, we have not developed our administration of general anesthesia to the level you have in America."

I asked him about his surgical societies. In every city of large size in the Soviet Union, he volunteered, there were large surgical societies, and they discussed interesting problems at their meetings. He asked about our societies and seemed pleased to know that I was a member of the American College of Surgeons. I asked him if he had any agency similar to our American Board of Surgery; he responded by saying that the Russian medical profession had extensive training programs, but that one reached eminence only after he was in his middle to late forties. I told him that I recognized the great disparity in doctors' prestige in Moscow, and that if I had to practice there, I would certainly aspire to be a professor such as he. Then, I asked how one gets to be a professor, and he answered smilingly, "Hard work, knowledge of medicine, proper contacts and good fortune." He also added, "You have to work at it for 25 to 30 years. Age has its wisdom, you know."

The Professor then introduced his assistants, who kindly showed us the patients with congenital cardiac disease. There must have been 30 patients with tetralogy of Fallot and patent ductus arteriosus to be operated on. He let me examine several on whom he had recently operated. We discussed Blalock, Taussig and Pott. He was high in his approbation and praise for Dr. Bla-

lock, so much so that I suspected that he must have been a resident of his, but this he denied.

While discussing various operations for the correction of tetralogy of Fallot, the Doctor (though I was given the impression that the title of Mister was used for a surgeon as in England) told me that at his institute about 50 Blalock-Taussig operations and 50 operations for patent ductus arteriosus were performed last year. He described a connection between the superior vena cava and the pulmonary artery. His diagrams were more explicit than our conversation, since I did not know exactly what he was talking about. This acknowledgment prompted my excellent interpreter, Mrs. Irene Finagine, to say, "When you know what you are talking about and he knows what he is talking about, interpreting is easy; when you do not know what you are talking about, and he does know what he is talking about, it is difficult; but when neither of you knows, it is impossible." I might interject here that Mrs. Finagine was not trained in medical language; yet she was able to make a most creditable translation. It did seem rather odd that the third person through whom the translation was passing really was not fully understanding what we were talking about. This she volunteered later.

We toured the institute's catheterization and angiocardiology "setups," and they were not unlike our own. Then we went to the operating room, and it, too, was similar to ours. There was a glass enclosure around the top of the operating room where students could observe the operation taking place below. On this same level there was a television set, used to televise operations, but, as in many of our own institutions, its cover had gathered a considerable amount of dust.

Next Professor Rovnov showed me the Russian instrument for suturing blood vessels together. This was a neat and unique application of an old German instrument, the von Petz clamp for stomach surgery. He pointed this fact out to me. In all deference, however, the innovation, in my opinion, makes it a Russian invention. The instrument greatly facilitates the suturing of vessels and saves a considerable amount of time. There were many other specially designed instruments for closing the bronchus stump, for suturing the intestine together, et cetera.

The blood vessel suturing instrument was adaptable to the suturing of tendons and nerves. The Russians, however, had a different manner of suturing nerves together and, incidentally, the

best I have seen. A metal crimp is placed around both ends of the severed nerve, and the nerve is cut flush with the crimp. Another metal crimp is then placed over the first two, the ones around the two nerve endings, much in the same fashion as if one were splicing a cable without anticipating tension on the cable.

I asked if I could buy one of the blood vessel suturing instruments. The Professor responded that he was a medical man and not a business man. I told him that in our country sometimes one had to be some of both. He said, yes, he understood that and that was the reason he liked his country. I told him that was also the reason I liked mine. He laughed. I had some slides of a recent resection of an aortic aneurysm which I had performed just prior to the trip, and I asked him if the Russian doctors had been able to use their instruments on dacron grafts. He said that to do so required a special modification of the instrument and that one was currently being made, but they did not have one at this time.

We briefly discussed the work of Dr. Demikhov of the "two-headed dog" fame, and as best I could ascertain the Russians have not solved the antigen-antibody reaction which prevents successful transplantation of organs for long periods of time. They have severed a dog's leg, perfused it for eight hours, and sutured it to the same dog again with survival and function being maintained two years thereafter. Some of these experiments are greatly facilitated by their suturing instruments.

On departure, I gave Professor Rovnov a small pocket pen flashlight, which seemed to intrigue him. Battery replacement, however, may be a problem.

### Appraisal

Personally, I do not care for socialized medicine. The inadequacies and bureaucracy cause Russian medicine to suffer; yet, it appeared to me that it had produced great accomplishments over the previous system; to say the least, the doctors and the population had few complaints about the system and in fact praised it. If one can believe the statistics published in 1956, the system has been good for the Russian people. The 1913 to 1956 death rate dropped from 30.2 to 7.7; these figures may reflect the 1918 revolution. The 1956 birth rate was 17.3 per 1,000, about the same as our own. The 1896-1897 life expectancy was 32 years; the 1926-1927 life expectancy was 44



years; and the 1954-1955 life expectancy was 64 years. Thus in 60 years the life expectancy and birth rate have doubled.

Perhaps we should introduce into the undeveloped countries of the world, health insurance similar to our own; else, an attractive system of state medicine will develop out of default by free enterprise. The Russian doctors lack freedom of choice, as do the patients. The doctor sells his soul for an education, in that he can be forced into an industrial plant or sent to some remote Siberian area for five years regardless of his wishes. The physician's integrity, as in this country, was good, and he did the best for his patient that funds would allow. In the governmental priority system, medicine ranks below engineering, and Sputniks get more appropriations than hospitals. Medicine in the Soviet Union is geared to quantity and not quality, but there was good evidence that the latter is forthcoming. I saw no hospital that I thought was as good as those we have in Jacksonville. There was some private practice, but this appeared to be limited to the elite, though I am sure my Russian friends would not like that word. A physician has to acquire great fame in order to attract patients for a private practice. Even if the Russian doctors made me a king professor there, I would rather practice here. But then there's no place like home.

"Breathes there the man, with soul so dead,  
Who never to himself hath said,  
This is my own, my native land?"

The Russian doctors were most accommodat- ing and extremely cordial. They also seemed to be honest in their approach to problems as well as in the appraisal of their results. They, like us, are searching for the truth. In fact, there seems to be an international bond amongst men of the medical profession, and I felt it there as much as in Spain, France, Denmark and America. It is a sort of universal language, a common understand- ing, a love of truth and integrity, a search for a better way and a realization of a Greater Force than our own that keeps things in their proper perspective. We call it God; the Russians call it Nature.

850 May Street.

PLAN NOW TO ATTEND THE ANNUAL MEETING, APRIL 8-11, 1960, HOTELS ROBERT MEYER AND GEORGE WASHINGTON, JACKSONVILLE.

### American Medical Association 1959 Clinical Meeting Dallas, December 1-4

The first day of December will mark the opening of the Thirteenth Clinical Meeting of the American Medical Association in Dallas, Texas. This annual four day convention will be held in the beautiful new Memorial Auditorium within walking distance from the downtown section of this Southern metropolis which combines old-fashioned Texas hospitality with some of the most modern convention facilities in the nation. More than 3,500 physicians, mainly from the Southern and Southwestern states, are expected to attend. The 208 members of the House of Delegates will meet throughout the week at the Adolphus Hotel, meeting headquarters.

At the opening scientific session on December 1, Dr. Hubertus Strughold, Professor of Space Medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, will be the principal speaker. Dr. Strughold, often called "the father of space medicine," will discuss the role of medicine in the space age. Other subjects highlighting the scientific program include indications for hysterectomy, rheumatoid arthritis, colloidal isotopes and leukemia, treatment of diabetes, infectious diseases in children, tranquilizers in medical practice, surgical approaches to Parkinson's disease, congestive heart failure, peptic ulcer in rheumatoid arthritis, immunization and its future, children's eyes, obstetrical emergencies, hernia repair, premarital and marital counseling and anticoagulants and choice of drugs. The eight symposiums scheduled deal with anemia, the problem child, iatrogenic disease, soft tissue injury, biliary tract surgery, intestinal obstruction, carcinoma of the breast and cerebrovascular insufficiency.

In addition to the scientific program, which includes medical motion pictures, color television, nearly 100 scientific exhibits, and over 250 industrial exhibits in addition to lectures and symposiums, the Auditorium will house the "world's largest health fair," sponsored by the Dallas County Medical Society in conjunction with the American Medical Association. It will feature 150 educational exhibits, prepared by the American Medical Association, allied health groups and voluntary health organizations. They will be manned by members of the Dallas society. The fair will run from November 27 through December 7 and will be open to the public.



Another special feature to be held on November 30, the day before the Clinical Meeting opens, will be a national conference on the medical aspects of sports. Sponsored by the American Medical Association's Committee on the Medical Aspects of Sports, formerly the Committee on Injury in Sports, the conference will be open to athletic directors, coaches and trainers as well as interested physicians. The program will cover the general areas of the physiology and pharmacology of exercise, the training and conditioning of the athlete, and the prevention and treatment of injuries.

Dallas is the second Southern city to be host to a clinical session of the American Medical Association. This winter meeting was held in Miami in 1954. The Dallas meeting offers an excellent practical program for physicians interested in a first hand review of the latest approaches to patient care presented by 144 outstanding specialists from every field in medicine.

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### **The Florida Midwinter Seminar Of Ophthalmology and Otolaryngology Miami Beach, January 24-30, 1960**

The Fourteenth Annual Florida Midwinter Seminar of Ophthalmology and Otolaryngology will be held this season in January 1960, convening on January 24 and continuing through January 30. The Americana Hotel in the Bal Harbour section of Miami Beach has again been chosen for the meeting place. The Seminar will be presented in cooperation with College of Medicine of the University of Florida and the University of Miami School of Medicine.

The lectures on Ophthalmology are scheduled for January 25, 26 and 27. The lecturers will be Drs. Bernard Becker, of St. Louis; David C. Cogan, of Boston; Robert N. Shaffer, of San Francisco; Joseph A. C. Wadsworth, of New York City; and Frank B. Walsh, of Baltimore.

The lectures on Otolaryngology will follow on January 28, 29 and 30. Presenting these lectures will be Drs. Lawrence R. Boies, of Minneapolis; Maurice H. Cottle, of Chicago; Howard P. House, of Los Angeles; Merle Lawrence, of Ann Arbor, Mich.; and Joseph H. Ogura, of St. Louis.

About November 15 the complete program with a schedule of lectures and the titles of all papers will be sent out. The schedule will allow plenty of time for enjoyment of the vacation

facilities of Miami Beach. All meetings will be held from 8:30 a.m. to 1:30 p.m.

Sponsoring this winter graduate course which enjoys nationwide popularity are, in the Division of Ophthalmology, Drs. Shaler Richardson and Charles W. Boyd, of Jacksonville; Joseph W. Taylor Jr., of Tampa; and Kenneth S. Whitmer and Edward Norton, of Miami; and in the Division of Otolaryngology, Drs. Walter T. Hotchkiss, of Miami Beach; G. Dekle Taylor, of Jacksonville; Carl S. McLemore, of Orlando; and James R. Chandler Jr., of Miami.

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### **Notes From Second World Conference On Medical Education Chicago, August 30—September 4, 1959**

When the American Medical Association was organized in 1847, its main purpose was to improve medical education. Although it is apparent that great strides have been made in this direction, the recent Second World Conference on Medical Education held in Chicago emphasized the importance of our continued interest in this subject. Criticisms of our system by other nations and the elaboration of common problems served to expose many of our defects.

In discussing the undergraduate training, frequent mention was made of the fact that our medical schools are tending to emphasize medical research too much. This tendency was attributed to the fact that many countries now have a full generation of full time medical school teachers who have never been clinicians and they, like any good teachers will do, have inspired their students in the line of their own interests. Also, the great part which research funds now contribute to the financial support of medical schools tends to overemphasize this side of education. Many of the educational leaders, while recognizing the importance of training scientific reasoning and practice, think that many good clinicians are being shunted into another phase of medicine in which they are relatively inapt. Also, our scientific literature is being flooded with immature, redundant and inconclusive publications which should be put in the trash can before being mailed. One school we visited in Chicago seemed actually to be measuring its success by the number of papers published by its undergraduates. Everybody agreed that the public is in many instances being cheated out of the future use of good doctors.

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... resolved with  
VARIDASE<sup>1</sup>



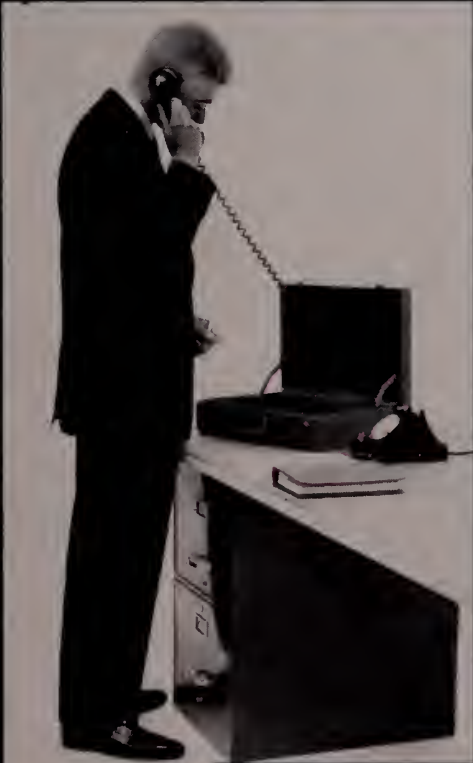
# **INFLAMMATORY DERMATOSIS**

rapidly spreading  
rhus dermatitis  
healed within  
a week<sup>1</sup>



# **INFECTED LACERATION**

marked reversal  
in 3 days...  
returned  
to school...  
closure advanced<sup>1</sup>



# **THROMBOPHLEBITIS**

back on his feet  
in a week after  
recurrent episode<sup>1</sup>



# **REFRACTORY CELLULITIS**

normal routine  
resumed after 4 days  
of VARIDASE<sup>1</sup>





In the field of postgraduate education and hospital training, the perennial problem of how to divide service and training has not been solved. The ideas varied all the way from that of Dr. Paul Fuchsig of Vienna that all postgraduate education should be training only and that internships and residences should all be voluntary only and of no prescribed time limit, leaving the length of time each student wanted to spend in the hospital completely up to him and his individual desires, to that of the South American doctors who are sent to school at government expense and must serve a certain amount of time free in the state-supported hospitals. There is no unanimity of opinion on the number of years needed for specialization training.

On certification for specialists many of the defects in our system were brought out, notably by the British. They operate on the premise that any man who finishes his basic medical training is potentially able to be trained in any specialty he selects and they give board examinations to candidates before they start their specialization training mainly to determine aptitude and interest. The only trouble with their system is that in order to practice a specialty in the countries where there is socialized medicine a hospital appointment must be obtained and there are more candidates than there are appointments, so that many otherwise qualified men are forced into general practice and there is nothing worse to foist on the public than a frustrated specialist-turned-general-practitioner. The English also say that any of our men who have undergone a long period of training for a specialty and then fail their Board examinations are going to find some place in the United States to practice their specialty willy-nilly, and I expect they are right.

One notable suggestion coming from South America was that all specialists should at first be required to be certified in general medicine or general surgery before going on to further specialization. This or a requirement to serve a period of general practice would in their opinion prevent overspecialization and the danger of specialists becoming technicians rather than doctors.

All countries seem to need and to encourage general practitioners, but very little in the way of concrete suggestions came out of the conference on the best way to train them. It was admitted that our country is behind many others in this respect. We have whole medical faculties who have no member who has ever done general prac-

tice, and it is a truism that a man cannot teach what he does not know. Many countries are utilizing general practitioners on their faculties, and others are finding preceptorships satisfactory. I was surprised to learn that some of the schools in England utilize the preceptorship method of training. It was generally agreed that students are not being encouraged in this country to enter general practice either because of the academic atmosphere or because of the poor outlook for adequate hospital training for this specialty. One of our own educational leaders denied vociferously that the medical faculties have anything to do with discouragement of general practice. He stated that greater specialization is simply a national trend, but he failed entirely to explain the fact that more freshmen medical students plan to go into general practice than do seniors.

The principle of apprenticeship for postgraduate training is still being utilized in some countries, notably England, where three years' apprenticeship is required of general practitioners after their hospital training.

In the matter of postgraduate training after the hospital period, most countries are experiencing our difficulty in reaching the men who most need it. Because of economic reasons, inability to obtain locum tenens or just plain apathy, the postgraduate courses are being poorly attended. In some areas compulsory measures are being instituted. In Austria, for instance, a law is being considered providing that any specialist who does not take a prescribed period of postgraduate education every three years will automatically lose his certification. In England the government pays the doctor's expenses for the postgraduate course and his locum tenens. This provision results in better utilization of the courses. Most doctors at the conference were definitely against the use of compulsory postgraduate courses.

The general practitioner, who probably has less time to keep up with literature and developments in all fields, was the person most considered. It was suggested that postgraduate education is certainly a two way street. The general practitioner seems to assume a spectator role instead of that of a participant. It was suggested that he should develop good instructors within his own ranks to be leaders in his own postgraduate courses and to be participants in all panels. All committees for planning postgraduate courses should have general practitioners as members.

When the vagus burns at both ends



## Pro-Banthine® with Dartal® moderates both mood and gastrointestinal spasm

The slow simmer of anxiety frequently causes kindred gastrointestinal overactivity. The spasticity and the accompanying distress of excess acid lead to loss of efficiency. Patients subject to such psychoenteric upsets require therapy to calm both ends of the vagus.

Pro-Banthine with Dartal contains two agents required for such dual therapy: Pro-Banthine to control and curtail the flare-ups of spasm, excess acidity and excess motility,

and Dartal to smother simmering anxiety and tension.

Pro-Banthine with Dartal contains 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride) in each tablet.

*Dosage:* One tablet three times a day.

G. D. Searle & Co., Chicago 80, Illinois.  
Research in the Service of Medicine.

It was rather obvious that there is a definite difference in motivation in the medical profession. In Europe personal prestige seems to be the main measure of success whereas in this country it is money. Of the two motivations I suspect the more ruthless and cruel can be the attainment of personal prestige. In general, the medical profession may be striving too hard to remain on a pedestal. As one speaker put it, a pedestal can so easily become a pillory.

HENRY L. HARRELL, M.D.

## OTHERS ARE SAYING

### The Plight of the Town Doctor

The command of the Master, "Be ye separate," has too long been a rallying cry for those in medicine who cloak themselves in the guise of "ethics," their wish being to remain aloof from their patients and community. This spirit of separation is in a large measure responsible for the periodic black eye given the medical profession by its more vociferous opposition. Not only is there a feeling among the laity that such separation and reserve connote indifference to their problems; but also, that in the face of criticism it is tantamount to admission of guilt.

In the public eye we are fast becoming a "minority group" instead of solid citizens of our community, and in the face of this onslaught the pedestal upon which we have been placed is crumbling. In these days of psychological advertising and salesmanship used by the opponents of medicine, as often as by tobacco companies, it behooves us to either resort to similar means of presenting our case—an alternative distasteful to most of us—or to join the ranks of our lay brothers down the street. In so doing we would abandon the myth of medical aristocracy and give evidence of our conviction that doctors are also human beings.

A businessman friend stopped me the other day and told me of several complaints he had encountered during the recent hospital drives. Two of them are as follows:

(1) "Doctors with all their enormous incomes are the only people who expect the public to build them a place to work." (2) "Doctors like to put people in hospitals to save themselves the effort of making house calls. At the same time this increases the number of patients who can be seen in a short time, thereby making more money."

We must begin a campaign of education to counter these erroneous claims. This same friend also wondered why it was so difficult to get doctors to join the Chamber of Commerce—certainly a place where a physician may make an ethical significant contribution to his community.

In the past, medical societies have often frowned on the practicing physician who has come into public prominence too often; although, in some measure, this physician's public activity was the only view many laymen had of their medical profession. Certainly then it seems apparent that it is necessary to put our best foot forward and see to it that the society is represented to the public by its better members and more reputable men rather than by individuals involved in litigation (whether it be traffic violation, malpractice, or felony), or by inaccurate radio, TV, movie portrayals, or as aristocrats in Cadillacs, lakefront homes, and 30-foot cruisers.

Part of the answer lies in the necessity for each of us to find a niche where our activities will be looked upon as a non-profit making credit to our profession and our community. The job may be as a coach of a little league team, church worker, civic-minded citizen, or grand mogul of




provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .  
**WHENEVER SULFAS ARE INDICATED**®

# KYNEX

Sulfamethoxypyridazine Lederle

0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York 

(Continued on page 619)



Your difficult rheumatic patient...

*on the job again*

through effective relief and rehabilitation

DISPATCHERS REPORT  
1949  
Symptoms  
Arthritis  
Tenderness  
Morning  
Evening  
Night  
Best  
Worst  
Location

For the patient  
who requires steroids

**PABALATE®-HC**

(PABALATE WITH HYDROCORTISONE)

Comprehensive synergistic  
combination of steroid and  
nonsteroid antirheumatics...  
full hormone effects on low  
hormone dosage... satisfactory  
remission of rheumatic  
symptoms in 85% of patients  
tested.

In each enteric-coated tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

For the patient who does not require steroids

**PABALATE®**

Reciprocally acting nonsteroid antirheumatics... more effective than salicylate alone.

In each enteric-coated tablet:

Sodium salicylate U.S.P.	0.3 Gm. (5 gr.)
Sodium para-aminobenzoate	0.3 Gm. (5 gr.)
Ascorbic acid	50.0 mg.

or for the patient  
who should avoid sodium

**PABALATE® - Sodium Free**

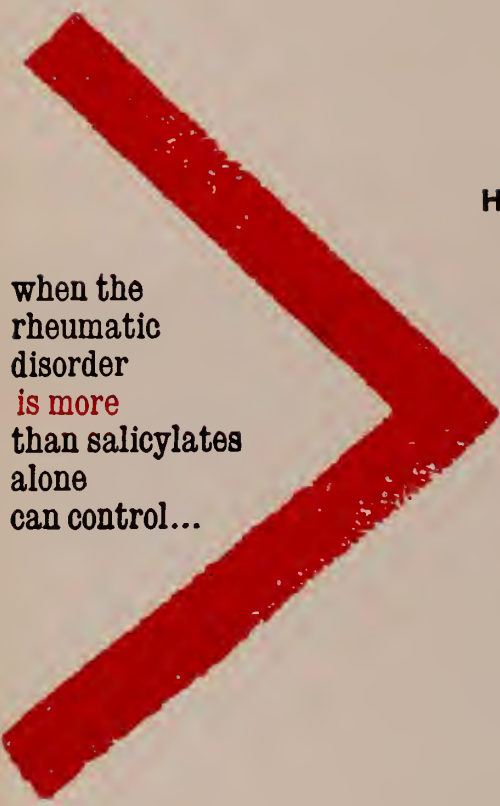
Pabalate, with sodium salts replaced by potassium salts.

In each enteric-coated tablet:

Potassium salicylate	0.3 Gm. (5 gr.)
Potassium para-aminobenzoate	0.3 Gm. (5 gr.)
Ascorbic acid	50.0 mg.

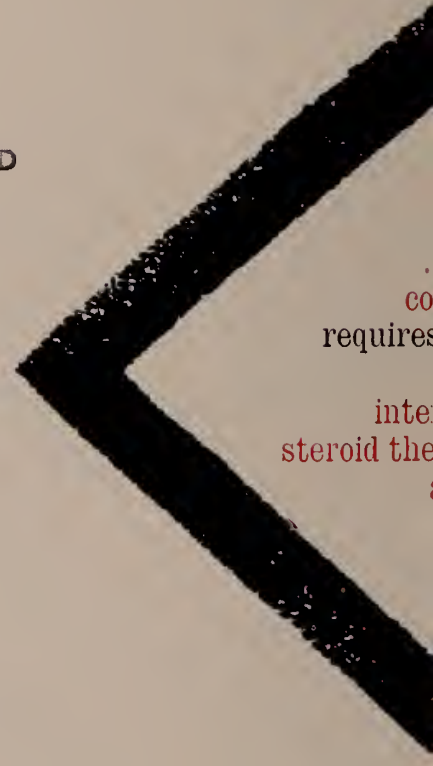
**PABALATE®**  **PABALATE®-HC**

For steroid or non-steroid therapy: SAFE DEPENDABLE ECONOMICAL



when the  
rheumatic  
disorder  
**is more**  
than salicylates  
alone  
can control...

MORE  
HIGHLY INDIVIDUALIZED  
THERAPY  
FOR THE  
RHEUMATIC  
"IN-BETWEEN"



co  
requires  
inter  
steroid the

# Aristo

### wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

*Indications:* Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

*Dosage:* Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

*Precautions:* All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone .....	0.5 mg.
Salicylamide .....	325 mg.
Dried Aluminum Hydroxide Gel .....	75 mg.
Ascorbic Acid .....	20 mg.

*Supply:* Bottles of 100 and 1,000.

  
**gesic®**  
Capsules  
Steroid-Analgesic Compound LEDERLE



ERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York





## the **disease** of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is “one of the most widespread and serious protozoan diseases of man,” yet “there is no parasite more often misdiagnosed than is *E. histolytica*.” Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

## new **Glarubin**

TABLETS

*specific for intestinal amebiasis*

### THE S. E. **MASSENGILL** COMPANY

BRISTOL, TENNESSEE

NEW YORK • KANSAS CITY • SAN FRANCISCO



*in  
peptic ulcer*

*Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."*

# Alglyn<sup>®</sup>

*Dihydroxy aluminum aminoacetate, N.N.R.*

In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in

patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY

tranquilization

anti-emetic

greater specificity  
of tranquilizing action  
—divorced from such  
"diffuse" effects as  
anti-emetic action  
—explains why

**Mellaril<sup>®</sup>**

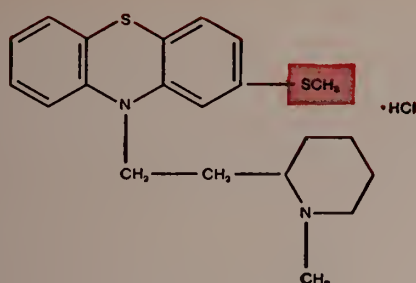
THIORIDAZINE HCl

is virtually free of such toxic effects as • jaundice • Parkinsonism • blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>\*</sup>



# a new advance in tranquilization: greater specificity of tranquilizing action results in fewer side effects



*The presence of a thiomethyl radical (S-CH<sub>3</sub>) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

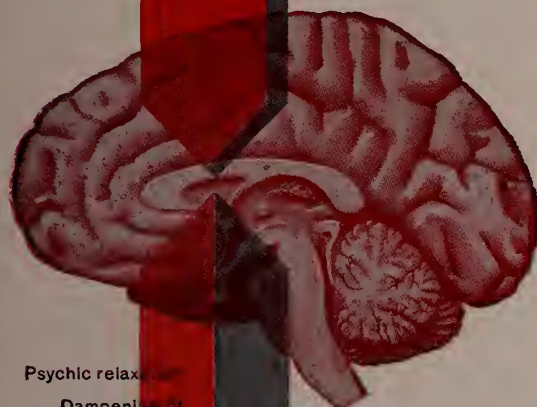
- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

## MELLARIL

### PSYCHIC RELAXATION

DAMPENING OF  
SYMPATHETIC AND  
PARASYMPATHETIC  
NERVOUS SYSTEM

Minimal suppression of vomiting  
Little effect on blood pressure  
and temperature regulation

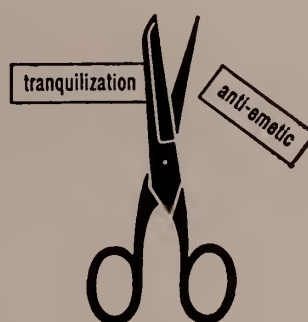


Psychic relaxation

Dampening of  
sympathetic and  
parasympathetic  
nervous system

Strong suppression of vomiting  
Dampening of blood pressure  
and temperature regulation

other  
phenothiazine-type  
tranquilizers



- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
<b>ADULTS:</b> Mental and Emotional Disturbances: MILD—where anxiety, apprehension and tension are present MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc. SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.: Ambulatory Hospitalized	10 mg. t.i.d.	20-60 mg.
	25 mg. t.i.d.	50-200 mg.
	100-mg. t.i.d.	200-400 mg.
	100 mg. t.i.d.	200-800 mg.
<b>CHILDREN:</b> BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

\*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959





when upper  
respiratory congestion  
is complicated  
by bacterial invaders

*TRISULFAMINIC provides logical therapy*

- for the patient ill with congestion and infection of the upper respiratory tract, as in purulent rhinitis, sinusitis, tonsillitis and otitis media, when caused by sulfa-susceptible bacteria;
- because secondary invasion by such bacteria so frequently follows the common cold.<sup>1</sup>

*the reasons for combining Triaminic with triple sulfas*

Triaminic and triple sulfas are not only pharmacologically *compatible*, they are a therapeutically *logical* combination for upper respiratory infections: Triaminic for effective decongestant relief from rhinitis, rhinorrhea and sinusitis;<sup>2</sup> triple sulfas for well-established antibacterial action.

The advantages of Trisulfaminic in upper respiratory infections include: proved effectiveness; safety; economy; ease of administration; less likelihood of sensitivity reactions;<sup>3</sup> compatibility with antibiotics and other antibacterial therapy. Provided also as Suspension for additional convenience.

# Trisulfaminic®

TRIAMINIC WITH TRIPLE SULFAS

*Available as TABLETS and SUSPENSION*

Each easy-to-swallow Trisulfaminic Tablet or 5 ml. teaspoonful of Suspension provides:

Triaminic® .....	25 mg.
(phenylpropanolamine HCl 12.5 mg.	
pheniramine maleate .....	6.25 mg.
pyrilamine maleate .....	6.25 mg.)
Trisulfapyrimidines, U.S.P. ....	0.5 Gm.

*Dosage:*

*Adults*—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12*—2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

*References:* 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

# internal and/or external attack

Whatever the bacterial infection seen in EENT, the foci respond rapidly to a suitable form of broad-spectrum ACHROMYCIN. In superficial cases, local therapy is often dramatic. In deep-seated conditions, ACHROMYCIN V capsules complement topical control for fast relief and remission.

# ACHROMYCIN®

Tetracycline Lederle



**e** Ophthalmic Oil Suspension 1%  
Ophthalmic Ointment 1%  
Ophthalmic Ointment 1%  
with Hydrocortisone 1.5%  
Ophthalmic Powder Sterilized

**e** Ear Solution

**n** Nasal Suspension  
with Hydrocortisone  
And Phenylephrine

**t** PHARYNGETS® Troches  
Troches

ACHROMYCIN V (Tetracycline with Citric Acid) Capsules

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York







# NIAMID<sup>\*</sup>

## reduces pain in angina pectoris

**NIAMID**, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients...

- reduces frequency of anginal episodes
- diminishes severity of attacks
- decreases nitroglycerin requirements
- renews sense of well-being

*Note:* Because of dramatic relief of symptoms and increased sense of well-being in anginal cases, it is advisable to caution the patient against overexertion.

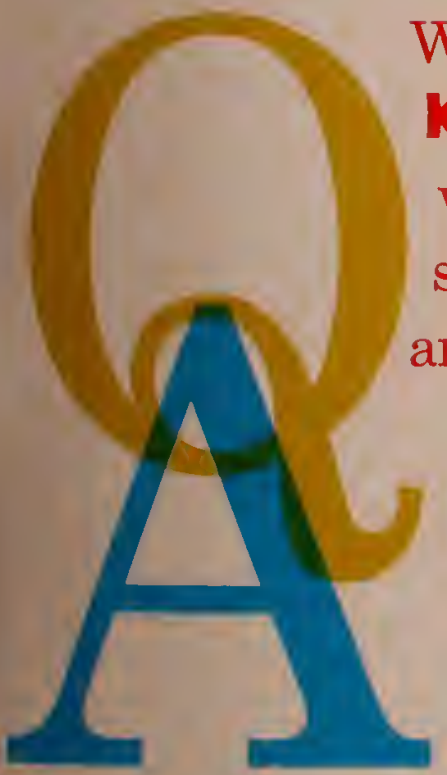
**DOSAGE:** Start with 75 mg. of NIAMID daily in single or divided doses. After 2 weeks or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others within 7 to 14 days. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

*A Professional Information Booklet giving detailed information on NIAMID is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

\*Trademark for nialamide

**Pfizer** Science for the world's well-being™





## Why should I use **KANTREX®** Injection\* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics<sup>3,4,10,12,13,17,18,20,21,23,24,25,27,30,33,35,37</sup>

—organisms such as *Staph. aureus*, *Staph. albus*, *A. aerogenes*, *E. coli*, *H. pertussis*, *K. pneumoniae*, *Neisseria* sp., *Shigella*, *Salmonella* and many strains of *B. proteus*.

**Q** *But if I use KANTREX Injection, won't that help make bacteria resistant to it also?*

Next page, please .....

**Q** *But if I use KANTREX Injection, won't that help make bacteria resistant to it also?*

**A** A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

**Q** *My impression is that KANTREX is just another neomycin. Isn't that so?*

**A** Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"<sup>14</sup>; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

**Q** *You mean that KANTREX Injection doesn't have the nephrotoxicity of neomycin?*

**A** Precisely. It's true that when KANTREX Injection is used, urinary casts — even slight albuminuria or microscopic hematuria — may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

**Q** *Then why do you recommend reduced dosage in patients with renal impairment?*

**A** Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads

to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

**Q** *Is that why we see reports of patients developing hearing loss during KANTREX Injection therapy?*

**A** Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function — with minimal risk of ototoxicity.

**Q** *Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use KANTREX Injection in such conditions?*

**A** Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus*, *A. aerogenes* and *E. coli*, even when renal impairment is present.

**Q** *What are the "proper precautions" in a patient with impaired renal function?*

**A** The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more



is seldom required because the clinical response to KANTREX Injection is so rapid.

**Q** *Why do you put so much emphasis on KANTREX's "rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

**A** There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.<sup>1,2,3,7,8,9,11,15,16,19,21,22,26,29,32,33</sup> Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."<sup>20</sup>

**Q** *Does KANTREX Injection cause blood dyscrasias?*

**A** In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

**Q** *Can I administer KANTREX Injection in any other way than by the intramuscular route?*

**A** Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

**Q** *So you think I ought to use KANTREX Injection as my first choice antibiotic in staph and gram-negative infections?*

**A** Yes — because all evidence to date indicates that it is bactericidal against a wide range of organisms...rapid acting...does not encourage development of bacterial resistance...is well tolerated in specified dosage...and has not caused any blood dyscrasias.

## KANTREX CAPSULES

*for local gastrointestinal therapy...  
not for systemic infections*

**Q** *Why can't I use KANTREX Capsules for systemic medication?*

**A** Because there is only negligible absorption of KANTREX from the gastrointestinal tract.<sup>3,5,6,8,28,34</sup> Thus, capsules cannot provide effective blood levels.

**Q** *Then what are KANTREX Capsules used for?*

**A** Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

**Q** *I've been using neomycin for preoperative bowel sterilization. Why should I switch to KANTREX Capsules?*

**A** Because KANTREX has been rated as "superior to neomycin" for this purpose.<sup>6</sup> It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.<sup>5,6</sup>

**Q** *What advantages do KANTREX Capsules offer me in the treatment of intestinal infections?*

**A** A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella*, *Shigella*, *Staph. aureus*, *E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."<sup>31</sup>

## KANTREX INJECTION

KANAMYCIN SULFATE INJECTION

### INDICATIONS

Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives": genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

### DOSAGE: INTRAMUSCULAR ROUTE

Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

### TOXICITY

When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

### OTHER ROUTES OF ADMINISTRATION

KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

### PRECAUTIONS

Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

### SUPPLY

Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.

KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

## CAPSULES

(for local gastrointestinal therapy; not for systemic medication)

### INDICATIONS AND DOSAGE

For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

### PRECAUTION

Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

### SUPPLY

KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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(Continued from page 608)

some fraternal or service organization. Each of these positions would enable a physician to demonstrate his "other side" and at the same time build up our stock in the eyes of the community.

Another fortunate side effect of an active civic life on the part of physicians is their influence on those teenagers who might someday consider medicine as a chosen profession. Such a program by physicians, I feel, would effect a change in public attitude and we would find open arms waiting for an almost lost leader of the community—the town doctor.

*Theodore Dippy, M.D.  
Quarterly Bulletin  
Orange County Medical Society  
July, August, September 1959.*

BLUE



SHIELD

### Voluntary Health Benefits for Federal Employees

It comes as no surprise that the law making health benefits available to federal employees is an accomplished fact. It has been long in the making, and only recently was the Federal Employees Health Benefits Act passed by the Congress and signed by the President. The fact that it is now a law definitely determines that, in some manner, federal employees will be provided the health benefits to which the members of the Congress believed they are entitled.

The law is detailed and complex, and its many ramifications can only be hazarded at present. This much is certain. Benefits will be made available and will be contracted for on be-

half of the federal employees by the Civil Service Commission. Nevertheless, it is a voluntary program, and the employees will have considerable latitude in their choice of plans. Each federal employee may *elect* to enroll in *one* of the following types of plans:

1. One Government-wide *service benefit plan* offering two levels of benefits. Service benefits can be provided only by Blue Shield-Blue Cross.
2. One Government-wide indemnity benefit plan offering two levels of benefits. Such benefits are typical of those currently being offered by commercial carriers.
3. Employee organization plans which are sponsored or underwritten and are administered in whole or a substantial part by employee organizations, and which are available only to members of the sponsoring organization. Some post office employee groups now have such plans.
4. Group practice prepayment plan similar to Group Health, Inc. of New York City. This is a closed panel system.

This new program will provide for federal employees health benefits similar to those available to employees of industry and business on a voluntary basis. It is a share-the-cost, employee participation program. The amount to be paid by the government varies somewhat, but, generally speaking, it will be one-half the cost of the low level offering of either Blue Shield-Blue Cross or the insurance industry. It is to provide uniform benefits, nationwide to all federal employees who elect to participate, with uniform rates for either service or indemnity type coverage.

The law is not specific as to the effective date, but does provide that government contributions



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Each tablet contains:

Vitamin A	8000 USP Units
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and employee withholdings will begin with the first pay period on or after July 1, 1960. To develop and inaugurate an extensive program of this nature cannot be done overnight. It will take time. If Blue Shield, together with Blue Cross, is to have something definite and of value to offer, planning must begin immediately. Blue Shield is face to face with a decision now. The answer cannot be delayed.

Is this a program in which Blue Shield-Blue Cross should have a part, one from which they cannot afford to remain aloof? There is only one choice if we firmly believe in the doctrine we have been advocating—the principle of voluntary health insurance which will offer free choice to the federal employees; if we believe that organized medicine must have a voice in shaping this program, that it can be truly medically sound only if the medical aspects are drafted and supervised by the medical profession. There is no other choice if we are going to back up our long-standing contention that voluntary health insurance

can do the task better than a compulsory program if but given the opportunity.

If we sincerely believe all these things, then we must work quickly and diligently to make certain that Blue Shield in Florida has an offer to make to the federal employees. Without such option the employee has no choice.

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Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design.

Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

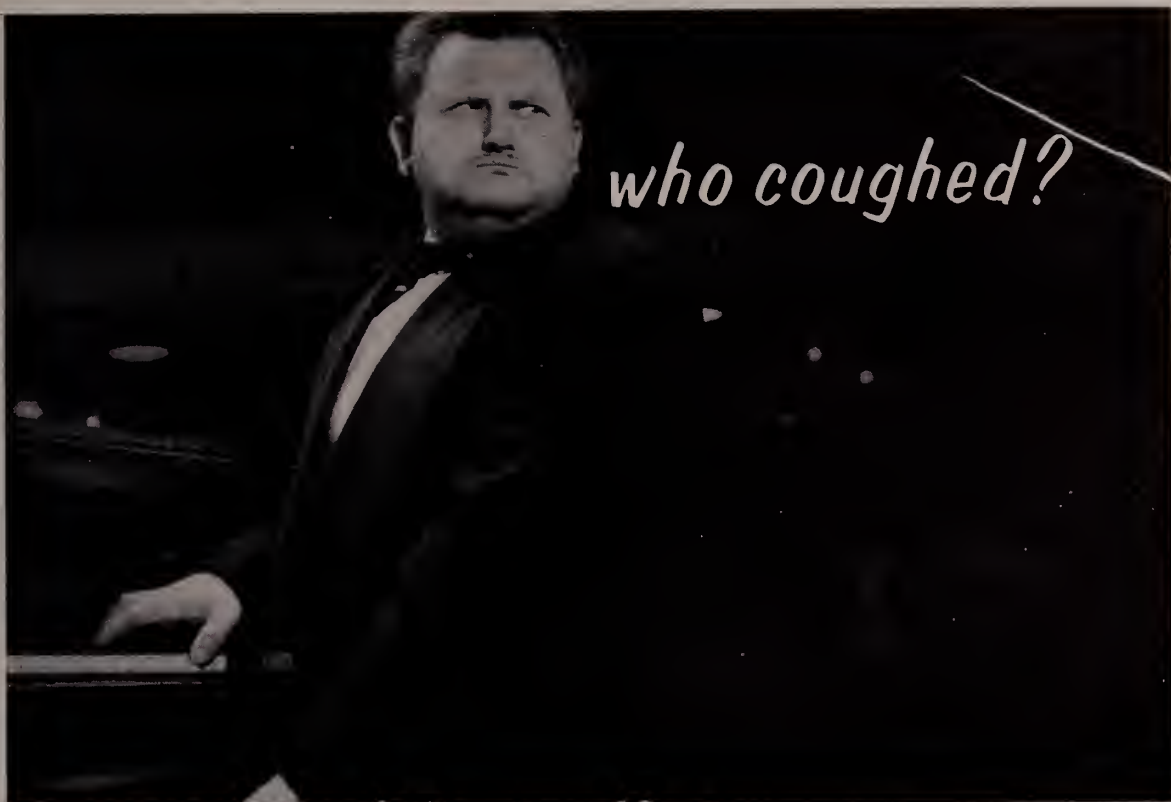


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*cough sedative / antihistamine / expectorant*

- relieves cough and associated symptoms in 15-20 minutes • effective for 6 hours or longer
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Hycodan<sup>®</sup>

Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	} 6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
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Sodium Citrate		85 mg.

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## STATE NEWS ITEMS

Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, was principal speaker at the installation dinner of the Florida Medical Secretaries and Assistants Association held October 10 at Orlando. The title of Dr. Jack's address was "Are Doctors Human?" Earlier that day, Dr. Jack addressed the Florida Chapter of the American Cancer Society at a meeting in St. Petersburg.

The Department of Ophthalmology of the Emory University School of Medicine announces a postgraduate course in Applied Ophthalmic Pathology on December 3-4 at Grady Memorial Hospital, Atlanta. The guest lecturers will be Dr. Lorenz Zimmerman of the Armed Forces Institute of Pathology, Washington, D. C., Dr. T. E. Sanders of Washington University, St. Louis, Dr. J. A. C. Wadsworth of Columbia Presbyterian Medical Center, New York, and Dr. J. T. Godwin of Atlanta.

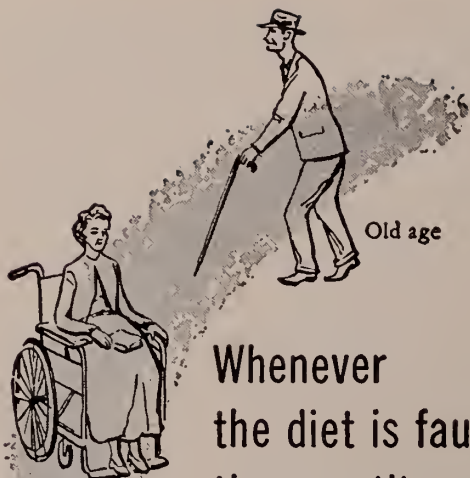
Dr. Leon S. Eisenman of Hialeah has been elected president of the Dade County Academy of General Practice. Serving with Dr. Eisenman for the coming year will be Dr. Daniel Kindler of Miami as vice president, and Dr. George B. Paxton Jr. of Miami as secretary. The next meeting of the Academy will be held December 20 at the Eden Roc Hotel on Miami Beach.

The Mid-Atlantic meeting of the United States Section, International College of Surgeons, scheduled for November 16-18 at Hot Springs, Va., has been cancelled. An announcement of the meeting was published in the September issue of The Journal of the Florida Medical Association.

Dr. Eugene G. Peek Sr. of Ocala, who was President of the Florida Medical Association in 1943, has been selected as an honorary member of Blue Key at the University of Florida in Gainesville. Members of Blue Key are chosen for leadership and scholarship in their respective fields of endeavor.

Dr. Ralph S. Sappenfield of Miami was one of the principal speakers at meetings of the French Society of Anesthesiologists and the Eu-

(Continued on page 628)



Old age

Convalescence



Adolescence



Infant diarrhea

Debilitating  
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Postoperatively

Whenever  
the diet is faulty,  
the appetite poor,  
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<i>Organism</i>	<i>Sensitive</i>	<i>Resistant</i>	<i>% Sensitive</i>
Staphylococci*	181	1	99.4
Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
Coliforms	34	3	91.8
Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

\*Includes many strains resistant to antibiotics.

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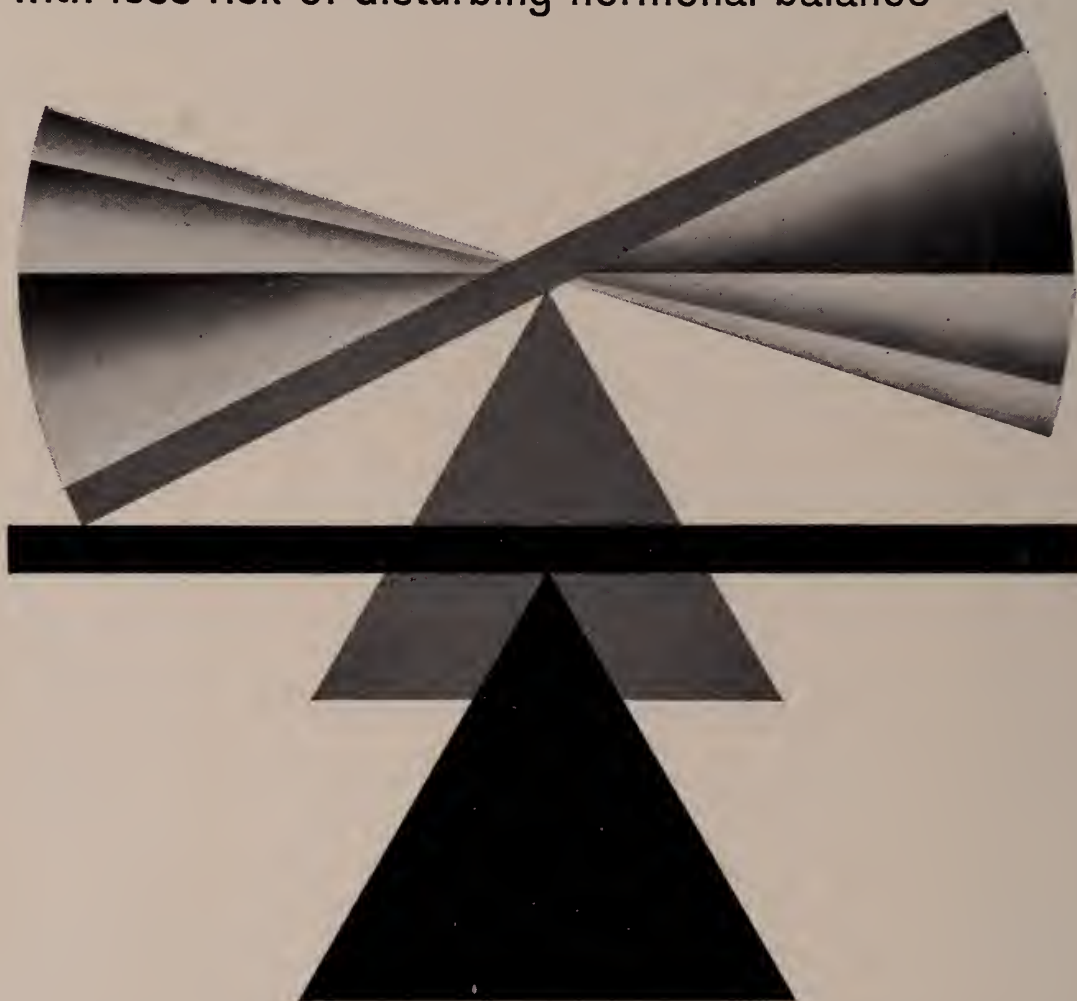
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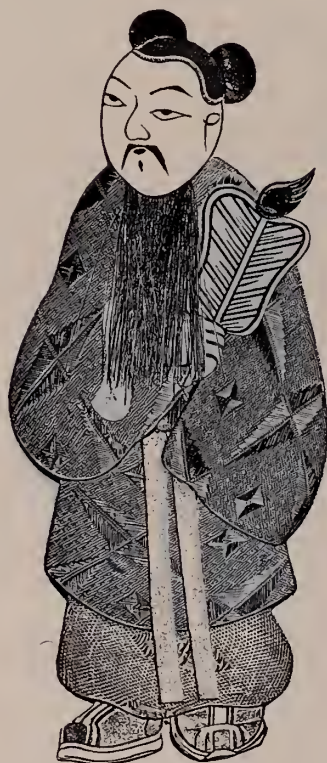
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(Continued from page 622)

ropean Society of Anesthesiologists held July 9-12 at Lyon, France. Dr. Sappenfield's subject was "Anesthesia and Fetal Mortality." In August, he addressed the anesthesiologists of West Germany in session at the Air Force Hospital in Weisbaden, Germany, on the subject "Changing Aspects of Premedication." Dr. Sappenfield is a member of the Board of Governors of the Florida Medical Association.

Dr. John S. Stewart of Fort Myers was made an active member of the American Roentgen Ray Society at the annual meeting held the latter part of September in Cincinnati.

Drs. Ralph W. Jack of Miami, president of the Florida Medical Association, and Eugene B. Maxwell of Tampa, First Vice President, attended the annual meeting of the Florida Nurses Association held October 13-15 at Orlando. Dr. Maxwell represented the Association at the banquet held the evening of the final day of the meeting.

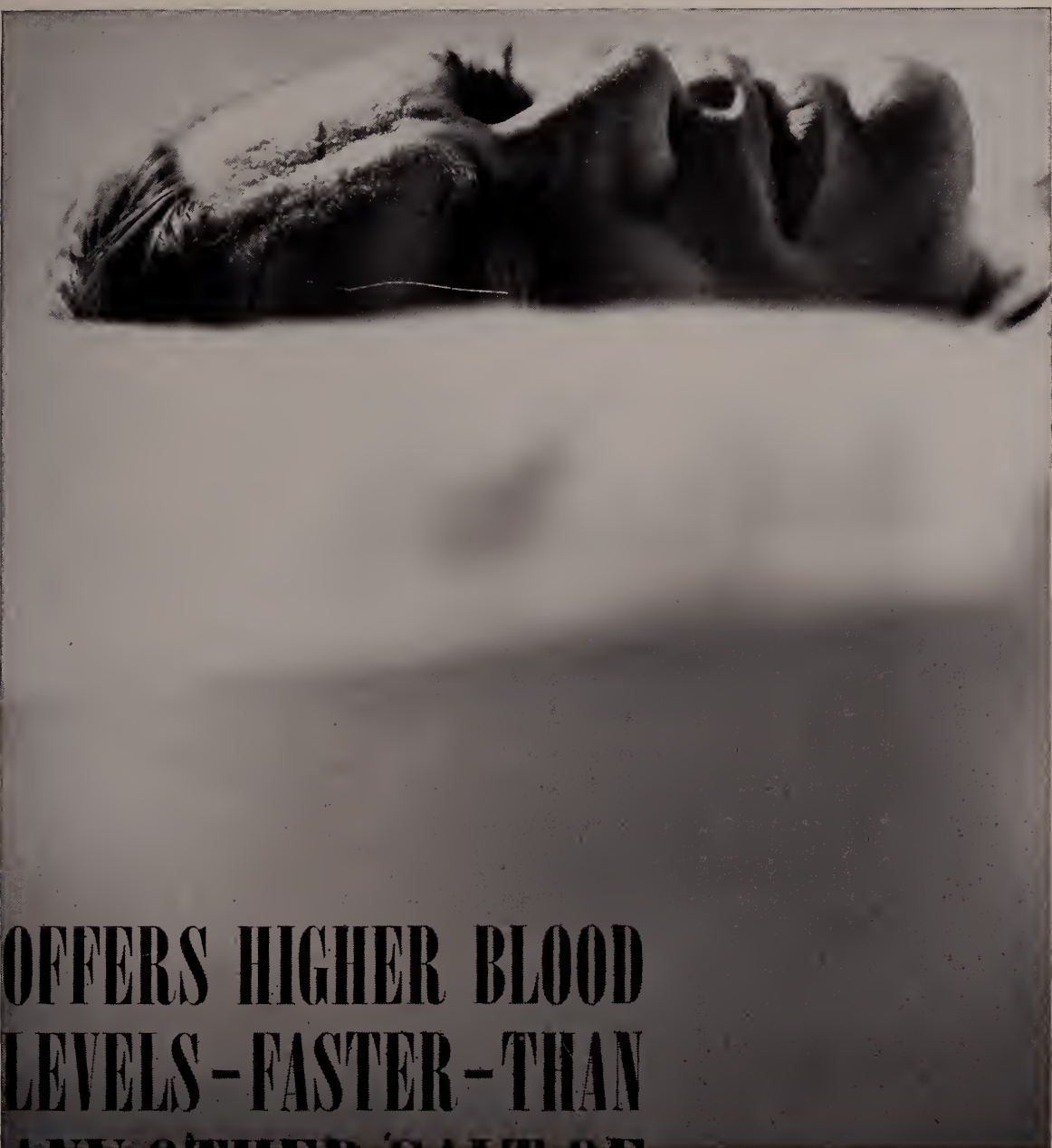
Drs. Ralph W. Jack of Miami, H. Phillip Hampton of Tampa and S. Carnes Harvard of Brooksville attended the American Medical Association Legislative Conference and the pre-conference meeting of the Committee on Aging held October 1-3 at St. Louis, Mo. Dr. Jack is President of the Florida Medical Association, and Drs. Hampton and Harvard are members of the Board of Governors.

Dr. Jere W. Annis of Lakeland has been appointed as a member of the Medical Advisory Committee of the Vocational Rehabilitation Division, Florida State Department of Education, for a term to expire December 31, 1961.

Dr. James N. Patterson of Tampa was principal speaker for a September meeting of the Rotary Club in Plant City. His subject was cancer.

Dr. William C. Thomas Jr. of Gainesville served as a member of the faculty for the Twenty-Fourth Annual Meeting of the Piedmont Post-Graduate Clinical Assembly held at Clemson, S. C., September 16-17. His program topics were "Disorders of Calcium Homeostasis," and "Problems in Diagnosis of Hyperparathyroidism." Dr.





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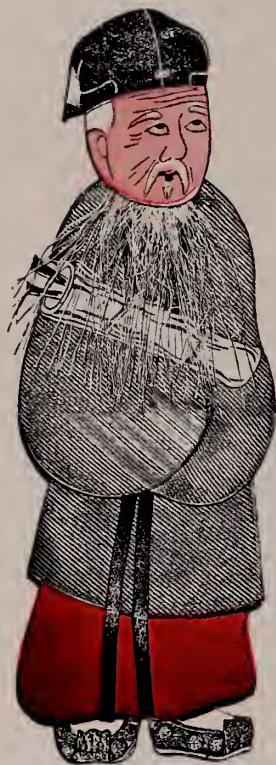
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*Supplied: Compocillin-VK Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.*



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Thomas is a member of the faculty of the College of Medicine, University of Florida.

Drs. Frank V. Chappell and Harold G. Nix of Tampa, Samuel P. Martin and Edward G. Byrne of Gainesville, M. Eugene Flipse of Miami, Wilson T. Sowder of Jacksonville and William R. Stinger of Tallahassee were among the group of Florida physicians participating in the program of the Thirty-First Annual Convention of the Florida Public Health Association held September 24-26 at Tampa.

Dr. James N. Patterson of Tampa has been in Boston where he did postgraduate work with Dr. William Dameshek on bone marrow transplantation.

Dr. Harriette E. Gillette of Gainesville has been elected secretary of the American Academy of Physical Medicine and Rehabilitation.

Dr. Frank G. Slaughter of Jacksonville was principal speaker at the Medical-Nursing Scholarship Convocation held October 6 at the University of Florida. The Convocation was sponsored jointly by the Colleges of Medicine and Nursing.

Dr. Harold O. Hallstrand of Miami has been elected a vice president of the United States Section of the International College of Surgeons.


Dr. Willard Machle Sr. of Boca Raton has been appointed North American Chairman of the committee which will organize and conduct the program of the Section on Industrial Medicine and Surgery for the 35th Anniversary Congress of the Pan American Medical Association scheduled for May 2-11, 1960, in Mexico City.

Dr. Thomas Z. Stanley of Pensacola has been appointed chairman of the medical division of the 1959 United Fund campaign in the greater Pensacola area.

A supplement to "Florida Law and the Mentally Ill and Handicapped" showing changes made by the 1959 legislature has been published by the Florida Association for Mental Health, Box 5841,

(Continued on page 641)



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and open stuffed noses orally

# Triaminic®

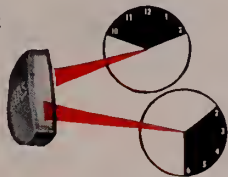
*the leading oral nasal decongestant*

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

*safer and more effective than topical medication<sup>1,2,3</sup>*

- systemic transport to all respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

*Relief with Triaminic is prompt  
and prolonged because of this  
special timed-release action . . .  
beneficial effect starts in  
minutes, lasts for hours*



*first*—the outer layer  
dissolves within minutes  
to produce 3 to 4 hours  
of relief

*then*—the core disintegrates  
to give 3 to 4 more hours  
of relief

**Each TRIAMINIC Tablet provides:**

Phenylpropanolamine HCl .....50 mg.  
Pheniramine maleate .....25 mg.  
Pyriminamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

**Dosage:** One tablet in the morning, mid-afternoon and at bedtime.

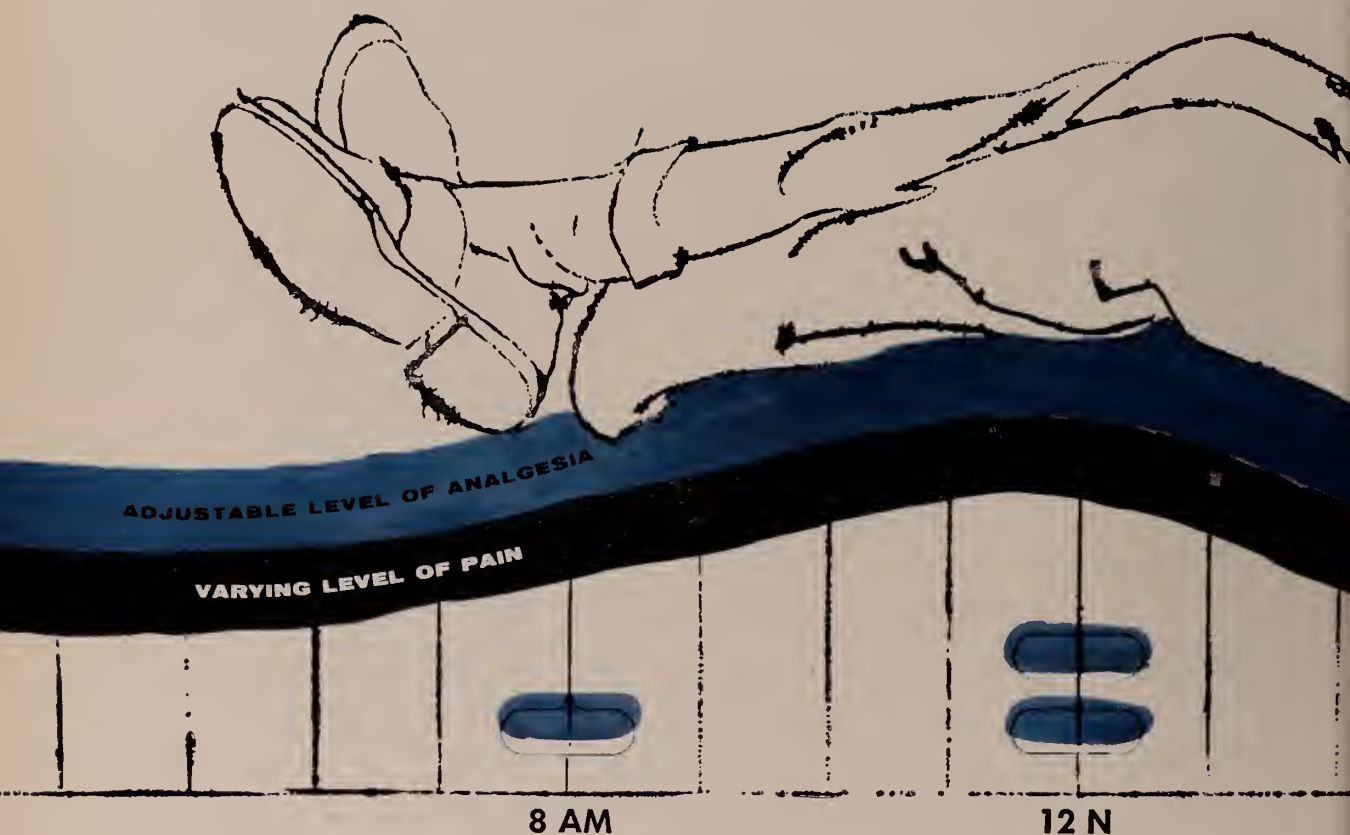
**References:** 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

**TRIAMINIC JUVELETS:** Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

**TRIAMINIC SYRUP** is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to  $\frac{1}{4}$  of a Triaminic Tablet. **Adults:** 2 tsp. 3-4 times a day; **children 6-12:** 1 tsp. 3-4 times a day; **children under 6:** in proportion.

**SMITH-DORSEY** • a division of The Wander Company • Lincoln, Nebraska





keep all patients\* pain-free at all times

- with the proper potency to match pain intensity
- with dosage flexibility to match pain variations

# Phenaphen<sup>®</sup>

or

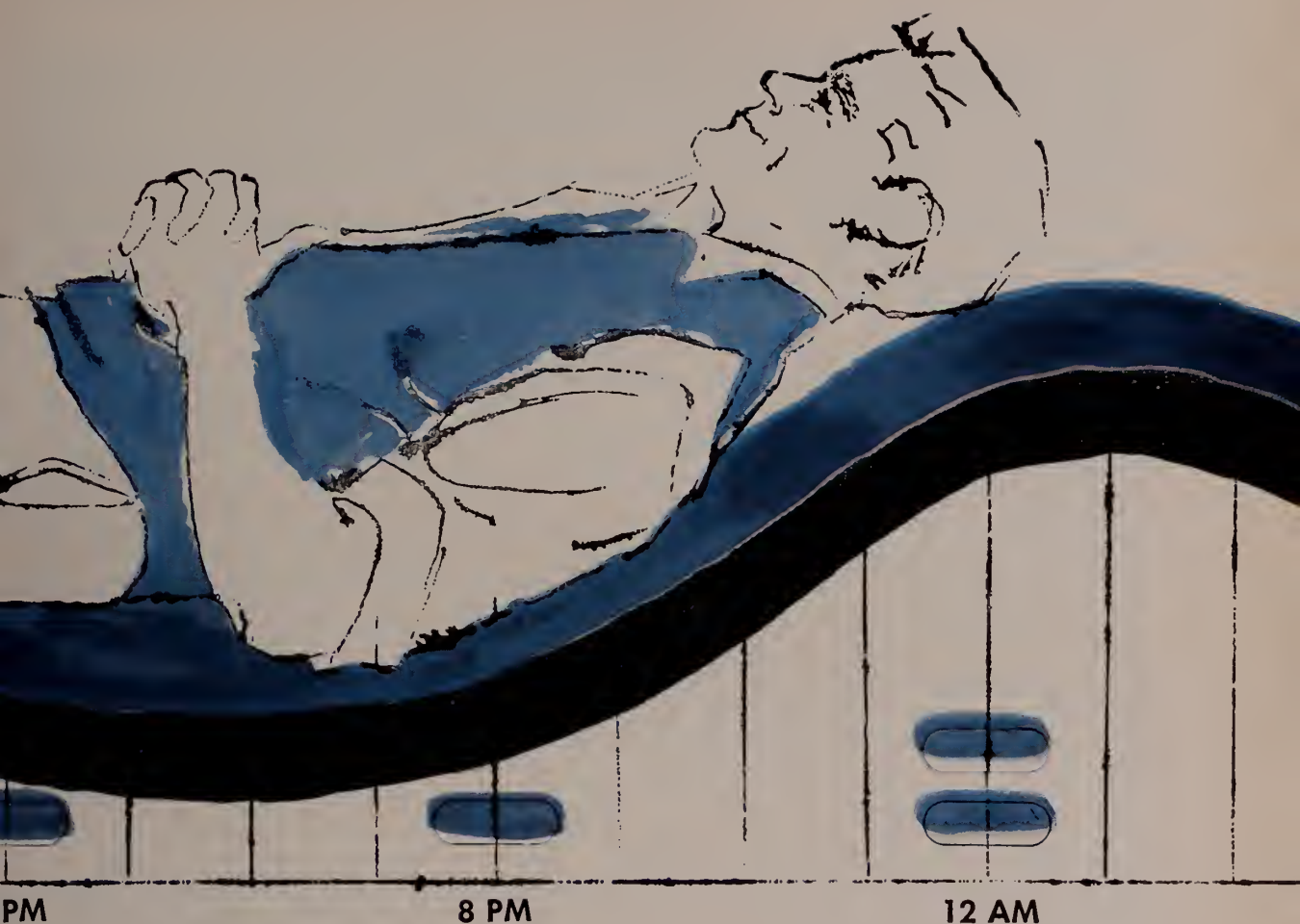
# Phenaphen<sup>®</sup> with Codeine



\*except those for whom recourse to morphine is inescapable.

**Robins**

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA  
Ethical Pharmaceuticals of Merit since 1878



Phenaphen and Phenaphen with Codeine provide a wide range of analgesia, plus complete dosage flexibility, to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

### Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Phenacetin (3 gr.) .....194.0 mg.  
Acetylsalicylic acid (2½ gr.).....162.0 mg.  
Phenobarbital (¼ gr.)..... 16.2 mg.  
Hyoscyamine sulfate.....0.031 mg.

### Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

### Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

### Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

# RESEARCH:

## key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have

been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.

The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.



A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!





What a great feeling to see *all* the pins go down . . .

*“Good for you!”*

A STRIKE! You did it—your side wins the game. Now, “Champ,” relax—reach for a rewarding glass of beer. More than a thirst-quencher, beer is the light, bright beverage just bubbling with life. A glass of beer adds so much fun to so many occasions. And it really picks you up, too!

*Beer Belongs—to the fun of living!*



United States Brewers Foundation  
CHARTERED 1862



Beer's rich in wonderful, healthful things. Nature's own choice barley malt, hops, minerals, and the purest water. Good wholesome beer or ale perks you up—won't let you down.

ATARAX


PASSPORT  
TO  
TRANQUILITY




## Passport

 a universal record of effectiveness


In anxiety, tension and agitation, ATARAX "... produced a more favorable state of calm and tranquility than any drug previously used."<sup>1</sup>

 widest latitude of safety and flexibility

No serious adverse reaction ever documented — five dosage forms and sizes

 chemically distinct among tranquilizers

Not a phenothiazine or a meprobamate

 added frontiers of usefulness

These unique benefits in specific indications

**ANTIHISTAMINIC  
ANTIARRHYTHMIC  
ANTISECRETORY**

**BACKED BY  
A WORLD OF  
EXPERIENCE**

**Dosage:** ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN — 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.  
**Supplied:** Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

**References:** 1. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy 29:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. 33:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

# ATARAX<sup>®</sup>

(brand of hydroxyzine)



New York 17, N. Y.  
Division, Chas. Pfizer & Co., Inc.  
Science for the World's Well-Being



*relieve the tension—and control its G.I. sequelae*



# ...Pathibamate®

meprobamate with PATHILON® tridihexethyl chloride Lederle

*for relieving tension and curbing hypermotility  
and excessive secretion in G. I. disorders*

**PATHIBAMATE** combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.)—a tranquilizer and muscle-relaxant widely accepted for the effective management of tension and anxiety

**PATHILON** (25 mg.)—an anticholinergic long noted for producing prompt symptomatic relief through peripheral, atropine-like action, yet with few side effects

*now available...*

## ***PATHIBAMATE-200 Tablets***

200 mg. meprobamate • 25 mg. PATHILON

*for more flexible control of G. I. trauma and tension  
smooth, sugar-coated, easy-to-swallow*

**PATHIBAMATE-400** and **PATHIBAMATE-200** are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

**Supplied:** **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; **PATHILON** tridihexethyl chloride 25 mg.

**PATHIBAMATE-200**—Each tablet (yellow, coated) contains meprobamate, 200 mg.; **PATHILON** tridihexethyl chloride, 25 mg.

**Administration and Dosage:** **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

**PATHIBAMATE-200**—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

**Contraindications:** glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



**Incremin<sup>®</sup>**  
Lysine-Vitamins Lederle  
with **iron** Syrup  
for the  
undersized  
underweight child

**build appetite**  
with  
B complex  
vitamins

**prevent  
nutritional  
anemia**  
with ferric pyrophosphate,  
a form of iron  
exceptionally  
well-tolerated

**promote  
protein uptake**  
with the  
potentiating effect  
of I-Lysine on  
low-grade  
protein foods

*in taste-tempting  
cherry flavor*  
Average dosage, 1 teaspoonful  
(5 cc.) contains:  
I-Lysine HCl . . . . . 300 mg.  
Vitamin B<sub>12</sub> Crystalline . . . 25 mcgm.  
Thiamine HCl (B<sub>1</sub>) . . . . . 10 mg.  
Pyridoxine HCl (B<sub>6</sub>) . . . . . 5 mg.  
Ferric Pyrophosphate (Soluble) . 250 mg.  
Iron (as Ferric Pyrophosphate) . 30 mg.  
Sorbitol . . . . . 3.5 Gm.  
Alcohol . . . . . .75%  
Bottles of 4 and 16 fl. oz.





(Continued from page 630)

Jacksonville 7. The original publication was distributed last year. Copies of the supplement may be obtained from the Florida Association for Mental Health.

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, will be one of the featured speakers at the annual meeting of the Florida Hospital Association being held at Jacksonville December 2-4.

Dr. Albert V. Hardy of Jacksonville, assistant state health officer, was in Geneva, Switzerland, early in August where he served as a consultant to the group which is being established by the World Health Organization to study acute intestinal disorders. From Geneva, he expected to go to Yugoslavia. Dr. Grace C. Hardy accompanied her husband on the trip abroad.

The annual meeting of the Greater Miami Society of Psychiatry and Neurology was held September 28. At that time, the following officers were elected for the coming year: Dr. Frederick LeDrew, president; Dr. William Corwin, vice president, and Dr. Irwin S. Jacobs, secretary-treasurer.

A meeting of the Southern Chapter of the American College of Chest Physicians is being held November 15-16 in the Biltmore Hotel at Atlanta immediately prior to the meeting of the Southern Medical Association. Dr. DeWitt C. Daughtry of Miami is chairman of the program committee and has extended an invitation to the meeting to all members of the Florida Medical Association who may be in Atlanta for the meeting of the Southern Medical Association.

Dr. L. Roland Young of Daytona Beach attended the Seminar in Neurology at the College of Medicine, University of Florida, Gainesville, the last of September.

The annual meeting of the Southern Thoracic Surgical Association is being held November 19-21 in the Edgewater Gulf Hotel at Edgewater Park, Miss., according to announcement by Dr. Hawley H. Seiler of Tampa, secretary. Dr. Edward F. Parker of Charleston, S. C., is president of the Association.

Dr. Henry L. Harrell of Ocala attended the Second World Conference on Medical Education held the first of September in Chicago.

Both **CENTRAL** and **PERIPHERAL**



control of cough

**SYNEPHRICOL<sup>®</sup>** cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines

Central Antitussive Effect — mild, dependable  
Topical Decongestion — prompt, prolonged

plus

Antihistaminic and Expectorant Action

Winthrop

LABORATORIES  
NEW YORK 18, N. Y.

Each teaspoonful (4 cc.) contains:

Hydrocodone bitartrate	5.0 mg.
Proprietary antihistamine	4.0 mg.
Dihydrocodeine bitartrate	1.0 mg.
Polysorbate emulsifier	7.0 mg.
Ammonium chloride	7.0 mg.
Menthol	1.0 mg.
Chloroform	0.0 — 0.1
Alcohol	8%

BOTTLES OF 16 FL. OZ.

EXEMPT NARCOTIC



Feeling better is part of getting better

# Hasamal

**Each HASAMAL tablet contains:**

Phenobarbital . . . . . 16.2 mg. ( $\frac{1}{4}$  gr.)  
 Acetylsalicylic Acid . . . . . 162.5 mg. ( $2\frac{1}{2}$  gr.)  
 Acetophenetidin . . . . . 162.5 mg. ( $2\frac{1}{2}$  gr.)  
 Hyoscyamus Alkaloids . . . . . 0.0337 mg.  
 (Equiv. to  $\frac{1}{4}$  gr. Ext. Hyoscyamus)

Dose: One or 2 tablets, repeated as necessary.

The HASKELL family of graduated analgesics . . . select the analgesic according to the degree of pain:

HASAMAL—Formula above

HASACODE—Hasamal formula with  $\frac{1}{4}$  gr. Codeine Phosphate

HASACODE "STRONG"—Hasamal formula with  $\frac{1}{2}$  gr. Codeine Phosphate

to relieve the discomforts of upper respiratory infections

- relieve pain and tensions
  - reduce fever
  - stop excessive nasal secretions
  - without unwanted diaphoresis\*
- (especially important for ambulant patients)

\*original Haskell formulation

CHARLES C. **HASKELL** & COMPANY, Richmond, Virginia

*for  
the  
tense  
and  
nervous  
patient*



**relief comes fast and comfortably**

- does not produce autonomic side reactions
- does not impair mental efficiency, motor control, or normal behavior.

*Usual Dosage:* One or two 400 mg. tablets t.i.d.

*Supplied:* 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS\*—400 mg. unmarked, coated tablets.

**Miltown<sup>®</sup>**

meprobamate (Wallace)



**WALLACE LABORATORIES / New Brunswick, N. J.**

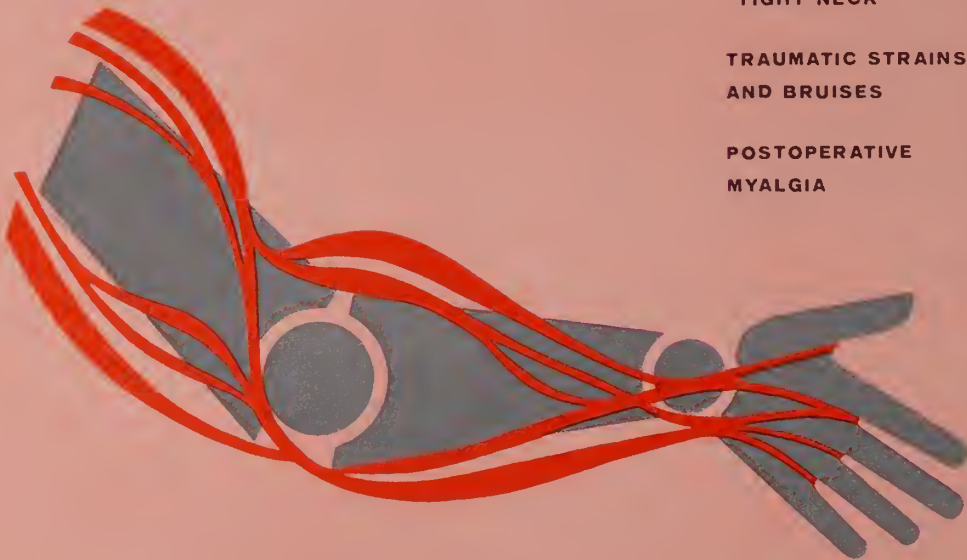


**NOW**

*... a new way  
to relieve pain  
and stiffness  
in muscles  
and joints*

*indicated in:*

MUSCLE STIFFNESS  
LUMBOSACRAL STRAIN  
SACROILIAC STRAIN  
WHIPLASH INJURY  
BURSITIS  
SPRAINS  
TENOSYNOVITIS  
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FIBROMYOSITIS  
LOW BACK PAIN  
DISC SYNDROME  
SPRAINED BACK  
"TIGHT NECK"  
TRAUMATIC STRAINS  
AND BRUISES  
POSTOPERATIVE  
MYALGIA



- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMATIC pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

# SOMA<sup>TM</sup>

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- More specific than salicylates
- Less drastic than steroids
- More effective than muscle relaxants

**SOMA** has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

**ACTS FAST.** Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

**NOTABLY SAFE.** Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

**EASY TO USE.** Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

**SUPPLIED:** Bottles of 50 white coated 350 mg. tablets.

*Literature and samples on request.*



WALLACE LABORATORIES, NEW BRUNSWICK, N. J.



**improves hearing**

**arlidin**

brand of nylidrin hydrochloride N.N.D.

In patients with disturbances of the inner ear, Arlidin produced remission of their chief complaint (impaired hearing, tinnitus or vertigo) in over 50% of cases. "Significant hearing improvement" occurred in 32 of 75 patients." Rubin and Anderson<sup>1</sup> attribute these symptoms of circulatory disorders of the inner ear to "labyrinthine artery insufficiency" due to spasm or obstruction of the vessels. They presumed that improvement could be produced by an agent capable of increasing blood flow and consider that the efficacy of Arlidin in this condition is due to its superior vasodilating and vasorelaxant effects.

1. Rubin, W., and Anderson, J. R.: *Angiology*, Oct. 1958.



# Arlidin®

helps relieve  
tinnitus,  
imbalance,  
impaired hearing  
in inner ear  
circulatory disorders

**Other indications:** Arlidin is often effective where other vasodilators fail . . . in intermittent claudication of thromboangiitis and arteriosclerosis obliterans . . . also useful in night leg cramps, "cold" legs and hands, Raynaud's syndrome, ischemic ulcers.

Arlidin is available in 6 mg. scored tablets. Parenteral Arlidin — 5 mg. per cc., in 1 cc. ampuls and 10 cc. multiple dose vials. See PDR for dosage and packaging.

Samples of Arlidin and reprint of Rubin-Anderson paper on request.

**U. S. vitamin & pharmaceutical corporation**

Arlington-Funk Laboratories, division  
250 East 43rd Street, New York 17, N. Y.

*Malpractice Prophylaxis*

REASSURE—BUT DON'T  
PROMISE A CURE

*Specialized Service  
makes our doctor safer*

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**MEDICAL PROTECTIVE COMPANY**  
FORT WAYNE, INDIANA

Professional Protection Exclusively  
since 1899

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**JUST ONE TABLET DAILY**

provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .  
**WHENEVER SULFAS ARE INDICATED**

**KYNEX**

Sulfamethoxypyridazine Lederle

0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

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Advertising rates for this column are \$5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

**ULTRA DESIRABILITY:** Nine room professional suite. 1000 square feet or less. 503 West Platt, Tampa. Phone 8-1600, 8-1686.

**DOCTOR'S OFFICES:** Available in ultra modern professional building, adjacent to finest home development in Sarasota. For information—contact Mr. Lench, Box 3740 or call Ringling 6-8832.

**WANTED:** Radiologist seeking associate—congenial Orlando area. Limited volume, currently diagnosis only. Some hospital work. Florida license required. Write 69-322, P.O. Box 2411, Jacksonville, Fla.

**NEW DOCTORS OFFICE IN MELBOURNE—**Pediatrician or General Practitioner: New offices in fast growing Melbourne near Missile Base. Pediatrician or General Practitioner will start with tremendous practice. Write or call Mr. Kelly E. George, Dairy Rd., Melbourne, Fla.

**WANTED:** General physician, specialist and internist to associate with well-established medical group in fast growing, high class residential area of St. Petersburg-Clearwater. Ground floor in new air-conditioned medical building. Large reception room, furnished. Excellent hospitals. Write Midway Medical Center, Box 8192, Madeira Beach, Fla.

**NEEDED:** Associate for general practice of medicine for north Florida area. Florida license required. Write 69-337, P. O. Box 2411, Jacksonville, Fla.

**NEEDED IMMEDIATELY:** A white physician, by a long established private sanitarium, treating nervous and mental diseases, and addiction problems. Also opportunity for psychosomatic medicine. Psychiatric experience preferred, not absolutely necessary. Semi-retired or retired physician not over 66 would be considered. Good salary; work not heavy. Write 69-339, P. O. Box 2411, Jacksonville, Fla.

**NEED AN ASSOCIATE?** 34 year old family man now in good Northern solo practice desires an association in a progressive location in Florida. Member AAGP and local medical society. Florida license. Five years out of topnotch internship. Write 69-346, P. O. Box 2411, Jacksonville, Fla.

**WANTED:** Associate in Dermatology. Excellent opportunity. Resort area. Write 69-343, P.O. Box 2411, Jacksonville, Fla.

**WANTED:** Associate for General Practice in community of 4,000 with excellent hospital, schools, fishing and hunting. Salary now and eventual partnership without investment. Write 69-348, P.O. Box 2411, Jacksonville, Fla.

**WANTED:** General Practitioner to join staff as a full time Medical Assistant in the Orange County Medical Clinic, Orlando, Florida. Salary open. Write A. C. Kirk Sr., M.D., 832 West Central Avenue., Orlando.

**LOCATION WANTED:** Ophthalmologist, Diplomate, extensive experience. Florida license. Accessibility to water more a factor than size of community or income. Write 69-349, P.O. Box 2411, Jacksonville, Fla.

**WANTED URGENTLY:** Physician—general practice, obstetrics, minor surgery, medicine. Florida license. Material assistance available. Community of 2800. Hospital 20 minutes paved highway. Contact Glades County Chamber of Commerce, Moore Haven, Fla.

**FOR SALE:** Well established medical practice, including furnishings and equipment—Coral Gables location. Write 69-351, P. O. Box 2411, Jacksonville, Fla.

**WANTED:** Two young associates for General Practice. One with training in anesthesia, the other in surgery, to be associated with General Practitioner with 28 bed hospital. Florida license required. Will guarantee suitable associates \$1000 per month with partnership later. Write 69-352, P. O. Box 2411, Jacksonville, Fla.

**LOCUM TENENS:** Two to two and a half months beginning first week January until third week March 1960. 1956 graduate Univ. of Miami. Florida license. Completing two and one half years in Navy as G.P. and Flight Surgeon; desires associateship to busy G.P. anywhere in Florida. If interested write. R. L. Belcher, Lt., MC, USNR, Box 11, Navy 230, c/o Postmaster, Seattle, Wash.

**SITUATION WANTED:** Otolaryngologist, age 35, certified; desires associateship in Florida. University trained. Florida license. Write 69-353, P. O. Box 2411, Jacksonville, Fla.

**WANTED:** Young General Practitioner for associateship with established physician in greater Jacksonville area. General and industrial practice. Write 69-350, P. O. Box 2411, Jacksonville, Fla.

**POSITION WANTED:** Experienced RPT desires chief therapist position in hospital or clinic. Male, 28, Caucasian, married, veteran. Write David Shelton, 324 South 27th Ave., Omaha, Nebraska.

**AVAILABLE MAY 1960:** General Practitioner with 3 years experience. Desires location in growing area. Hospital privileges nearby. Write Harry Rein, M.D., 101 Butts St., Ft. Benning, Ga.

**FOR SALE:** Used medical equipment in excellent condition: Microtherm diathermy; medi-sanar ultra sound machine, portable; Mattern X-Ray machine; Office music system. Write 69-296, P. O. Box 2411, Jacksonville, Fla.

## NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baker, Thomas J., Miami  
Bauer, Robert E., Miami Beach  
Burr, Janice M., Coral Gables  
Cebula, Jerome M., Orlando  
Clark, Warren A., Brooksville  
Dickinson, Thomas C., Orlando  
Fields, Jerome, Hialeah  
Hester, Frederick C. III, Eustis  
Johnson, Douglas M., New Port Richey  
Maseda, Ramon L., Coral Gables  
Radin, Arthur, Miami  
Skaggs, Thomas W., Miami  
Talmage, Edward A., Miami  
Tirone, Antonio P., Miami  
Towbin, Samuel, Miami  
Turner, Thomas A., Leesburg  
Wemple, Jay N., Coral Gables

*immortals of chinese mythology:*



Lu Tung-pin

This scholarly but fierce mystic earned his place in the Taoist pantheon by slaying dragons with a magic sword

...this experience-tested steroid has earned its place in twentieth-century medicine by its unsurpassed results in acute and chronic steroid-responsive disorders

# METICORTEN

METICORTEN,<sup>®</sup> brand of prednisone, 5 mg. tablets.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a full-color, handmade, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

8-922

*Schering*



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WOMAN'S AUXILIARY  
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 MRS. CLYDE MILLER JR., Parliamentarian.....Pensacola

## Essay Contest

"Socialized medicine is degrading and demoralizing."

"I don't think I care to meet Dr. Politician, M.D."

"Socialized medicine??? Who wants to be a number?"

"I rather like being an individual. Under the socialistic system people seem to be numbers."

"If we don't destroy socialism *today* it will haunt us all of our *tomorrows*."

These remarks are not those of experienced adults but those of teenagers, high school students, who have been engaged in studying and writing about the problem of socialized medicine. One student said, "Can't we do something about this situation? It worries me, for most of the people I talk to seem indifferent and wonder why I am so upset. Believe me, I'm talking about it to everyone."

County and state medical societies and auxiliaries have an opportunity to further increase the knowledge of young people and their parents concerning the everpresent dangers of socialism. There are people who feel that the average American doesn't have sense enough to take care of himself in any phase of his life. To cover one part of this average American's life, they would like the Federal Government to become the purchaser and dispenser of medical care and medical needs. The term "socialized medicine" has become "compulsory health insurance." They mean the same thing—socialization in one more area of our existence.

*The Association of American Physicians and Surgeons* is sponsoring an essay contest with a choice of two topics:

"The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." It is by encouraging this contest at national, state and local levels that medical societies and auxiliaries can increase, through

(Continued on page 664)



provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .

WHENEVER SULFAS ARE INDICATED®

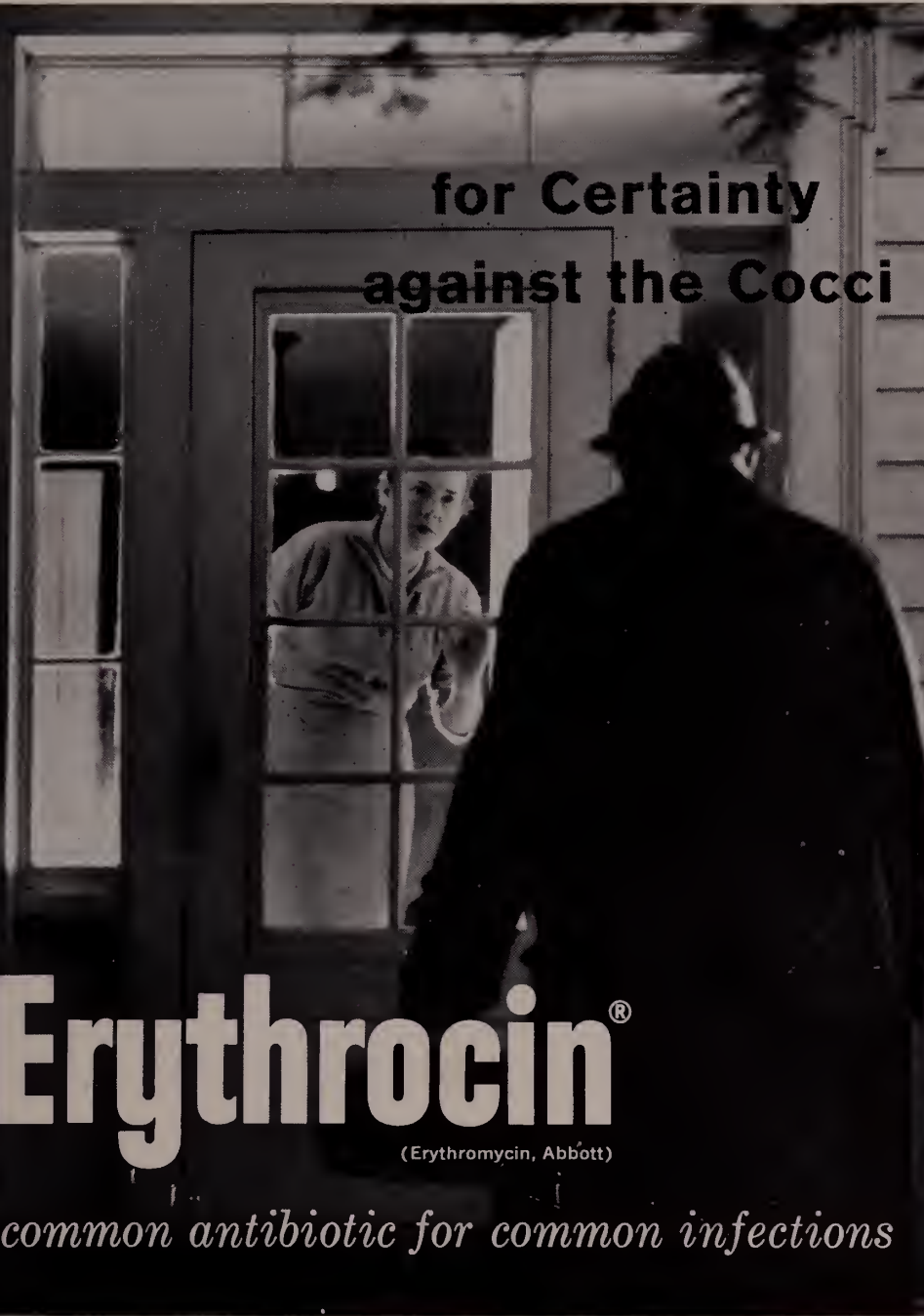
**KYNEX**

Sulfamethoxypyridazine Lederle

0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York





for Certainty  
against the Cocci

# Erythrocin<sup>®</sup>

(Erythromycin, Abbott)

*an uncommon antibiotic for common infections*

Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs<sup>®</sup> (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.



©FILMTABS—FILM-SEALED TABLETS, ABBOTT; U.S. PAT. NO. 2,881,085



**COUGH** promptly curbed by homarylamine—non-narcotic antitussive with the approximate potency of codeine.

**INFECTION** combated by three nonsystemic antibiotics—each active against common mouth and throat pathogens, all with relatively low sensitization potentials.

**IRRITATION** soothed by benzocaine—a topical anesthetic that promotes prolonged relief of inflamed or irritated tissues.

## **PENTAZETS<sup>®</sup> troches**

Homarylamine • Bacitracin • Tyrothricin • Neomycin • Benzocaine

**NEW PINEAPPLE FLAVOR** Overwhelmingly selected by a taste panel.

Available to your patients on your prescription only.

DOSAGE: Three to five troches daily for three to five days.

SUPPLIED: Vials of 12.



**MERCK SHARP & DOHME** DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

PENTAZETS is a trademark of Merck & Co., Inc.





Outstanding  
relief from  
torticollis and  
anxiety and  
tension states

with  
*Trancopal*<sup>®</sup>

THE FIRST-TRUE "TRANQUILAXANT"

# Here is what you can expect when you prescribe

---

## case profile no. 2840\*

A 55-year-old man complained of a painful, very stiff neck on the left side. There was marked muscle spasm that seemed to involve primarily the trapezius muscle. He had a severe headache, with the pain radiating down the left side of the neck to the shoulder. There were no other findings on physical examination and results of routine laboratory tests were normal.

Trancopal was prescribed in a dosage of 200 mg. q.i.d. The first and second dose of Trancopal gave only moderate relief. However, after the third dose, there was marked relief of the stiffness of the neck, as well as the headache and shoulder pain.

After the fourth dose, medication was gradually decreased and was discontinued on the sixth day. One week later, the patient had moderate recurrence of the torticollis, and Trancopal was again prescribed in doses of 200 mg. q.i.d. The patient obtained complete relief in one day and no further treatment was required.



for torticollis



# *Trancopal*<sup>®</sup>

THE FIRST TRUE "TRANQUILAXANT"

for anxiety and  
tension states



## case profile no. 3382\*

A 35-year-old woman, a professional model, had an acute, severe attack of anxiety. She was irrational and unable to eat, and was very restless.

Initial medication consisted of aspirin with codeine and later meprobamate. Neither was effective, and the patient's condition became worse. She had to be hospitalized because of the marked anxiety. Trancopal was then prescribed in a dosage of 200 mg. q.i.d., in addition to bed rest.

After the second dose of 200 mg. of Trancopal, the patient became calm and rational, and was able to eat. The dosage of Trancopal was gradually reduced to 100 mg. q.i.d. on the fourth hospital day, after which the patient was discharged and was able to return to her normal occupation.

*\*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.



# THE FIRST TRUE "TRANQUILAXANT" *Trancopal*

**potent MUSCLE RELAXANT**  
**effective TRANQUILIZER**

## Indications:

### Musculoskeletal<sup>1</sup>

Neck pain (torticollis, etc.)  
Low back pain (lumbago, etc.)  
Bursitis  
Rheumatoid arthritis  
Osteoarthritis  
Disc syndrome  
Fibrositis  
Ankle sprain, tennis elbow, etc.  
Myositis  
Postoperative muscle spasm

### Psychogenic<sup>1</sup>

Anxiety and tension states  
Dysmenorrhea  
Premenstrual tension  
Asthma  
Angina pectoris  
Alcoholism

**Dosage:** Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours. The higher dosage is recommended for the treatment of patients in the acute stages of painful musculoskeletal conditions, and anxiety and tension states. Children (5 to 12 yrs.), 50 mg. three or four times daily.

### Supply:



Trancopal Caplets®

100 mg. (peach colored, scored), bottles of 100.

**New  
strength** ▶



Trancopal Caplets

200 mg. (green colored, scored), bottles of 100.

"Chlormethazone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."<sup>2</sup>

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."<sup>3</sup>

". . . Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states."<sup>4</sup>

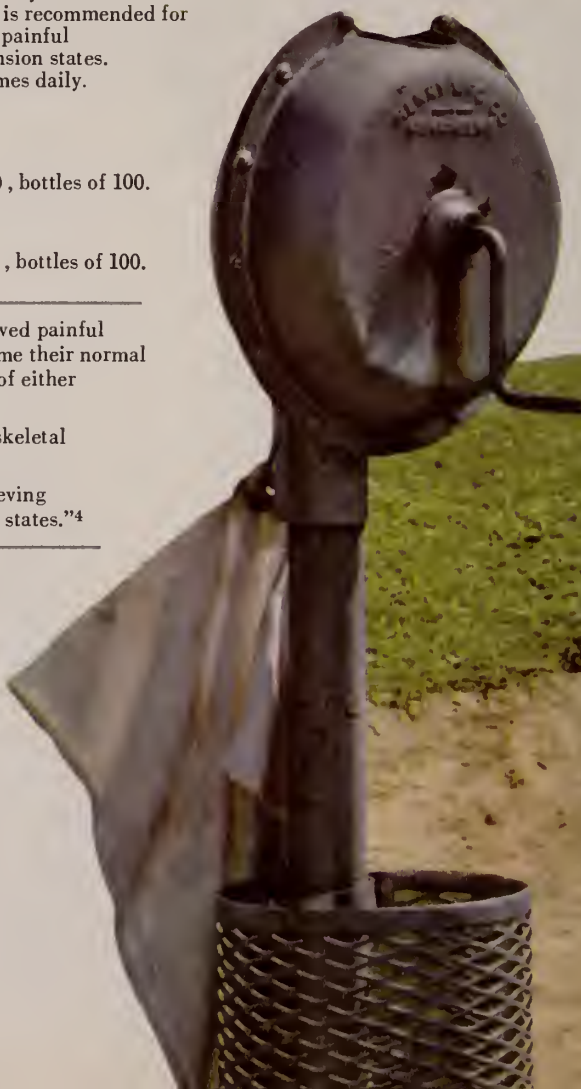
1. Collective Study, Department of Medical Research, Winthrop Laboratories.

2. Lichtman, A. L. (N.Y. Polyclinic M. Sch. & Hosp.): *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958.

3. Mullin, W. G., and Epifano, Leonard (Long Island College Hosp.): *Am. Pract. & Digest Treat.* To be published.

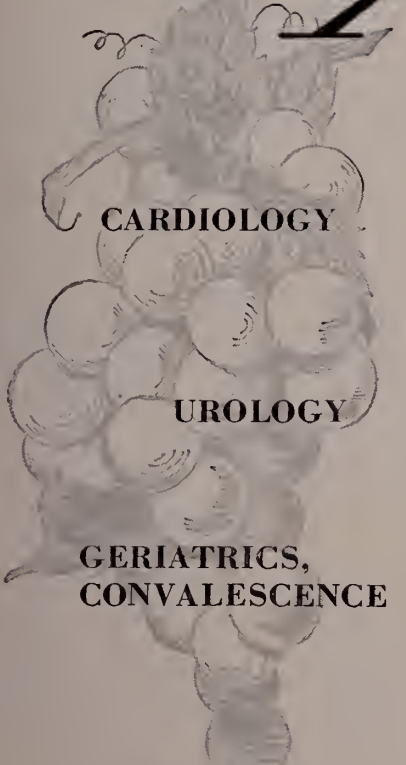
4. Ganz, S. E. (New York, N. Y.): *J. Indiana M. A.* 52:1134, July, 1959.

*Winthrop* **LABORATORIES**  
New York 18, New York



# R

## Recent research\* confirms the widening FIELD for WINE



**CARDIOLOGY**

**UROLOGY**

**GERIATRICS,  
CONVALESCENCE**

**GASTROENTEROLOGY**

**DIABETES**

---

WINE has been used with excellent effect for the relief of pain, discomfort, apprehension and anxiety in angina pectoris, thromboangiitis obliterans, Raynaud's disease and hypertension.

The judicious use of WINE can brighten the otherwise monotonous, unappealing diet in renal disease. It increases glomerular blood flow, stimulates diuresis, is nonirritating to the kidneys.

By stimulating appetite, supplying quick energy source, relaxing tensions and increasing morale, the prudent use of WINE has been described as a balm for the convalescent and "milk" for the aged.

In moderate amounts WINE increases gastric secretion, relaxes gastric tension and, therefore, is a valuable aid in the treatment of anorexia, hypochlorhydria, dyspepsia, spastic constipation and diarrhea.

In the normal diet of the diabetic, WINE can serve as an excellent energy source which does not require the participation of insulin.

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These and other therapeutic uses for wine are discussed in \*"Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.



# NEW

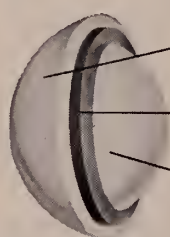
*"flavor-timed"*  
dual-action  
coronary vasodilator

# Dilcoron<sup>®</sup>

for **ANGINA PECTORIS**

**ORAL** (tablet swallowed whole)  
for dependable prophylaxis

**SUBLINGUAL-ORAL**  
for immediate and sustained relief



**Nitroglycerin**

—0.4 mg. (1/150 grain)—acts quickly

**Citrus "flavor-timer"**

—signals patient when to swallow

**Pentaerythritol tetranitrate**

—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient  
swallows the entire Dilcoron tablet  
on an empty stomach.

*Bottles of 100.*

**Average prophylactic dose:**

1 tablet four times daily  
( $\frac{1}{2}$  hour before meals and at bedtime).

**Therapeutic dose:**

1 tablet held under the tongue until citrus  
flavor disappears, then swallowed.

*Rx  
Dilcoron Tabs No. 100  
Sig. 1 tab. before meals  
and at bedtime.  
If attack occurs, place  
tablet under tongue,  
swallow when  
flavor disappears*



*Winthrop* **LABORATORIES**  
NEW YORK 18, N. Y.



“But,  
Doctor, I  
just can’t  
swallow a  
lot of  
tablets”

“Little mother, just  
**ONE**  
**BONADOXIN®**  
tablet stops morning sickness  
(you take it at bedtime)”



The formula tells why BONADOXIN quickly stops nausea and vomiting of pregnancy in 9 out of 10 cases.\* Each tiny BONADOXIN tablet contains: Meclizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement. More than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance excellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe cases may require another on arising. See PDR, p. 779.

BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

#### After Baby Comes

For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.\*

Each cc. contains:  
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

\*Bibliography available on request.



New York 17, New York • Division, Chas. Pfizer & Co., Inc. • Science for the World's Well-Being

greater antihypertensive effect...fewer side effects

# HYDRO PRES\*

**HYDRODIURIL**  
HYDROCHLOROTHIAZIDE

antihypertensive

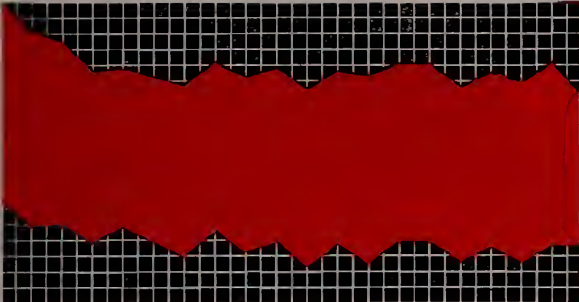
WITH

**RESERPINE**

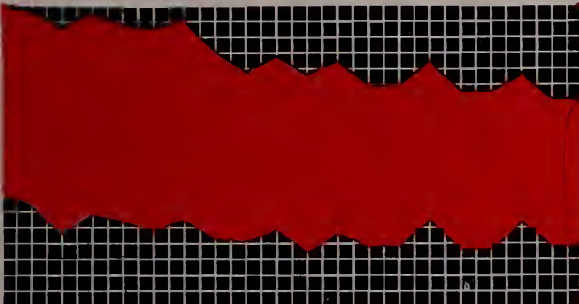
antihypertensive-  
tranquilizer



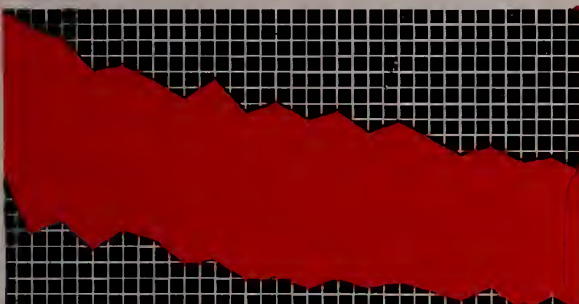
*For complete information  
write Professional Services,  
Dept. H, Merck Sharp & Dohme,  
West Point, Pa.*



**HYDRODIURIL** alone



**RESERPINE** alone



**HYDROPRES**  
much more effective  
than either of its  
components alone

- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

## HYDROPRES-25

25 mg. HYDRODIURIL, 0.125 mg. reserpine.  
One tablet one to four times a day.

## HYDROPRES-50

50 mg. HYDRODIURIL, 0.125 mg. reserpine.  
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine,  
their dosage must be cut in half when HYDROPRES is added.

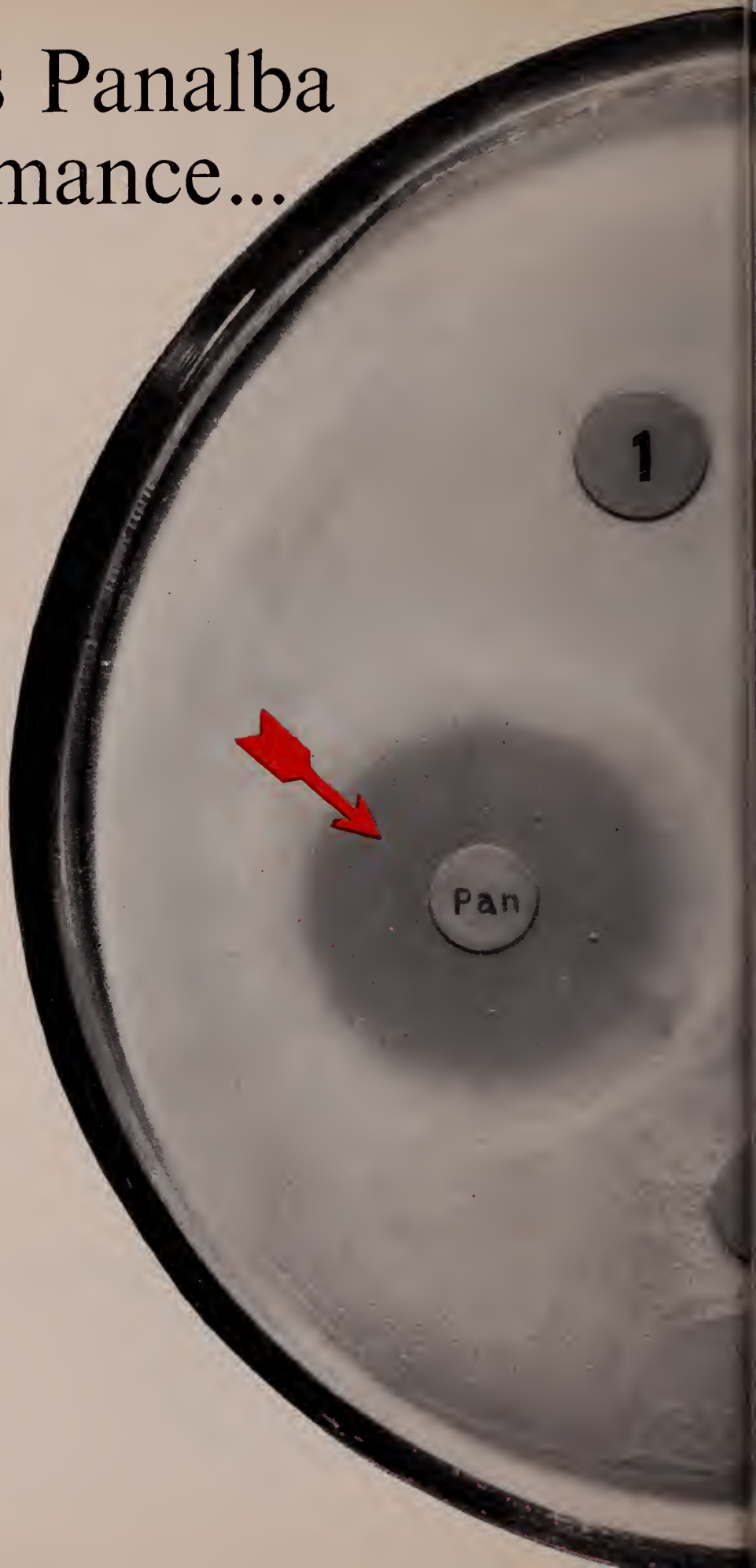


**MERCK SHARP & DOHME**, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

\*HYDRODIURIL AND HYDROPRES ARE TRADEMARKS OF MERCK & CO., INC.



This is Panalba  
performance...





# in pneumonia

... into a mixed culture of the three organisms commonly involved in pneumonia ... *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) ... we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient ... in *all* your patients with potentially-serious infections ... provide this extra protection with your prescription :

Dosage—1 or 2 capsules  
3 or 4 times a day.

Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.  
*Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.*

## Panalba\*


(Panmycin\* Phosphate plus Albamycin\*)

The broad-spectrum  
antibiotic of  
*first* resort

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan

TRADEMARK. REG. U. S. PAT. OFF.



it started  
as a  
"cold"...

to prevent  
the sequelae  
of u.r.i. ...  
and relieve the  
symptom complex

# ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound-Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.<sup>(1)</sup> To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HC1 (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: *Am. J. Hygiene* 71:122, Jan. 1933.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



# MAINSTAY

## OF RHEUMATOID ARTHRITIS THERAPY

# Plaquenil<sup>®</sup>

SULFATE

brand of hydroxychloroquine sulfate

### New Long Term Chemotherapy of RHEUMATOID ARTHRITIS

Whatever else may be needed from time to time in the management of individual cases, these drugs [Plaquenil and Aralen] should always be given a prolonged trial (at least six months) as the 'mainstay' of therapy."

*Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.*

The 4-aminoquinoline drugs (Plaquenil and Aralen) together with supplemental agents administered in nontoxic doses effectively maintained suppression of the disease in 83 per cent of 194 patients followed for 18 months."

*Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958.*

When used in tolerated dosage and over a sufficient period of time, there appears to be a tremendous therapeutic potential in the antimalarial drugs. . . . Plaquenil in this study did not have as many side effects as Aralen and thus appears to be a more practical compound."

*Cramer, Quentin (Kansas City): Missouri Med. 55:1203, Nov., 1958.*

Plaquenil (brand of hydroxychloroquine) and Aralen (brand of chloroquine), trademarks reg. U.S. Pat. Off.



**Plaquenil** is the hydroxy derivative of Aralen<sup>®</sup> and is available as Plaquenil sulfate in tablets of 200 mg. (bottles of 100).

#### Average Dosage:

**INITIAL**—400 to 600 mg. (1 tablet 2 or 3 times daily)

**MAINTENANCE**—200 to 400 mg. (1 tablet once or twice daily)

*Write for Plaquenil booklet discussing clinical experience, dosage, tolerance, precautions, etc., in detail.*

*Winthrop*

LABORATORIES • NEW YORK 17, N. Y.

# NO SALT... *but seasoned*

A meal of even the most colorful and the most meticulously prepared food can be dreary without salt. Neocurtasal, for the patient on a low sodium diet, brings back flavor to food and makes eating a pleasure once more. Neocurtasal is also valuable for preventing potassium deficiency (weakness, etc.) in patients on diuretic therapy with chlorothiazide or its derivatives.

## Neocurtasal<sup>®</sup>

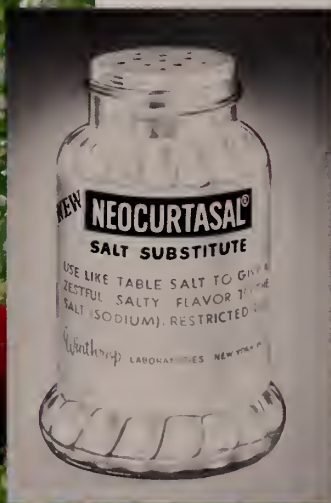
*An excellent salt replacement for*  
*Salt Free (LOW SODIUM) Diet*

*Neocurtasal contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate and potassium iodide (0.01 per cent)*

Supplied in  
2 oz. shakers  
and 8 oz. bottles.

*Sold Only  
through Drugstore*

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## Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her de-

votion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the

whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone. Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada





# avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4, 5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2, 4, 5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

**CALURIN** is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



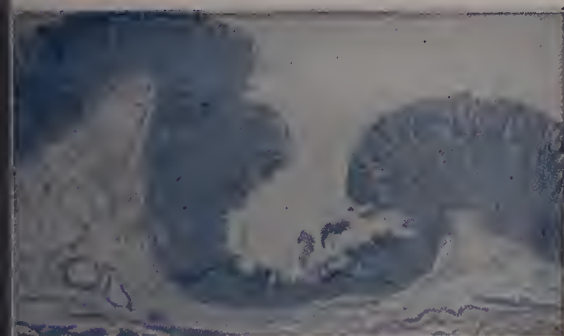
Regular aspirin crystals 24 hours after being mixed into water.



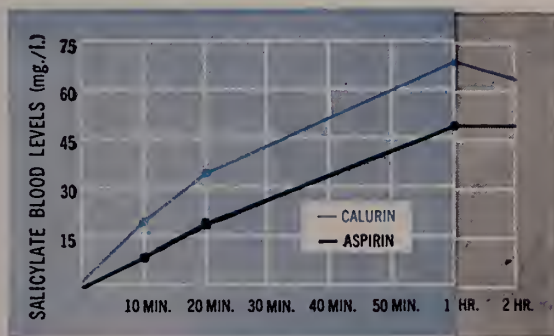
Calurin crystals in solution one minute after being mixed into water.

# CALURIN\*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



**Particle-induced ulceration** — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

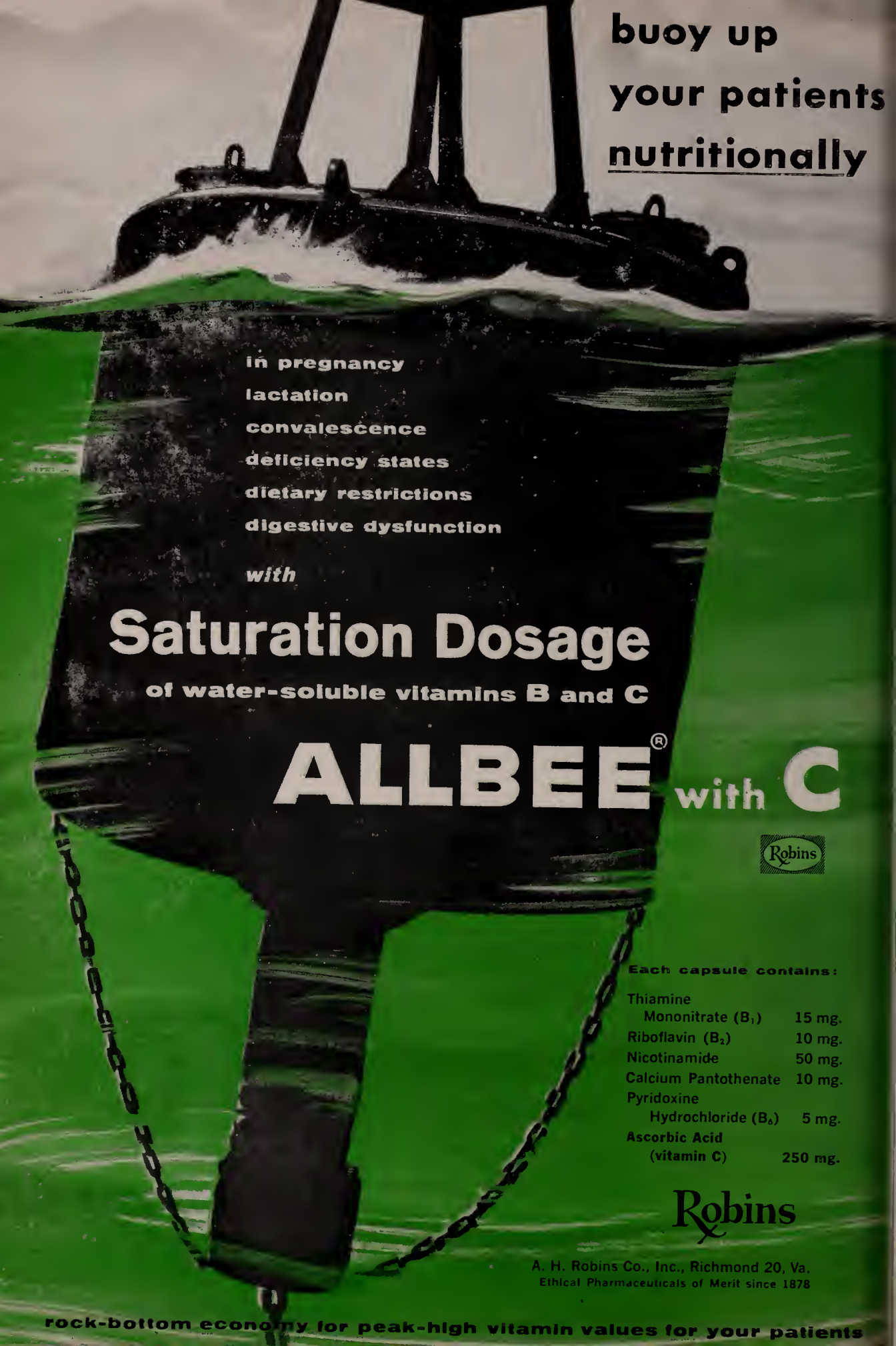
- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastrosopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

\*TRADEMARK



**buoy up  
your patients  
nutritionally**

**in pregnancy  
lactation  
convalescence  
deficiency states  
dietary restrictions  
digestive dysfunction**  
*with*

# **Saturation Dosage**

**of water-soluble vitamins B and C**

# **ALLBEE<sup>®</sup> with C**



**Each capsule contains:**

Thiamine	
Mononitrate (B <sub>1</sub> )	15 mg.
Riboflavin (B <sub>2</sub> )	10 mg.
Nicotinamide	50 mg.
Calcium Pantothenate	10 mg.
Pyridoxine	
Hydrochloride (B <sub>6</sub> )	5 mg.
Ascorbic Acid	
(vitamin C)	250 mg.

**Robins**

A. H. Robins Co., Inc., Richmond 20, Va.  
Ethical Pharmaceuticals of Merit since 1878

**rock-bottom economy for peak-high vitamin values for your patients**





Each tablet contains: Iron (Ferrous Sulfate Exsiccated 194 mg.), 58 mg.; Dioctyl Sodium Sulfosuccinate, 100 mg.; Vitamin A, 6000 U.S.P. Units; Vitamin D, 400 U.S.P. Units; Vitamin B<sub>1</sub> (Thiamine Mononitrate), 5 mg.; Vitamin B<sub>2</sub> (Riboflavin), 5 mg.; Vitamin B<sub>6</sub> (Pyridoxine HCl), 2 mg.; Vitamin B<sub>12</sub> Activity (Cobalamin Conc.), 2 mcg.; Vitamin C, 100 mg.; Folic Acid, 0.25 mg.; Niacinamide, 20 mg.; Calcium Pantothenate, 5 mg.; Calcium (Calcium Carbonate), 150 mg.; (Phosphorus free formula).

**strength and vitality...  
freedom from constipation**

# \*TERMINATAL® (Tablets, Benton)



**prenatal dietary supplement  
high iron content in a potent  
nutritional formula  
counteracts prenatal constipation  
sensibly packaged in re-usable  
nursing unit  
one-a-day dosage convenience**

Addition of dioctyl sodium sulfosuccinate to offset constipation of pregnancy by fecal softening makes TERMINATAL a *unique* high-potency dietary supplement for use to term.

*Supplied:* 100 TERMINATAL capsule-shaped tablets are packaged in a useful nursing bottle with nipple, ready for the infant's first formula.

**B** / **BENTON Laboratories** Hatboro, Pennsylvania  
Division of Air-Shields, Inc.

*(Continued from page 648)*

knowledge, protection for the American public against inroads of socialism.

Detailed information will be forthcoming but each of us should bear in mind: The doctor and his family are personal ambassadors for free enterprise and the right of private medical care. Everytime a thoughtless or selfish doctor is deliberately, willfully impossible to get, everytime a doctor knowingly charges an exorbitant fee, he destroys the work of thousands of good ambassadors.

Mrs. Sidney G. Kennedy Jr.

### BOOKS RECEIVED

**Ciba Foundation Symposium on Amino Acids and Peptides with Antimetabolic Activity.** Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 286. Illus. 28. Price, \$8.75. Boston, Little, Brown and Company, 1958.

This international symposium deals with the chemical, biochemical, biological or clinical properties of amino acid and peptide derivatives. In the broad sense, the only previous Ciba Foundation symposium touching on this subject was the 1952 program on Chemical Structure of Proteins. At this 1958 meeting attempts were made to answer such questions as "How far are these substances acting as true antagonists, with which part of cell metabolism do they interfere, what does the rather loose expression 'cytotoxic' mean in terms of the biologist and

biochemist, are there any connections between some anti-bacterial and antitumor drugs, and how many different kinds of action mechanisms are operating in the case of substances producing apparently similar or identical biological effects?"

**The Management of Fractures and Dislocations**—*An Atlas.* By Anthony F. DePalma, M.D. Vol. I, pp. 1-470; Vol. II, pp. 471-960. Illus. 1927. Price, \$35.00 set of two volumes. Philadelphia, W. B. Saunders Company, 1959.

This atlas was undertaken, as the author explains in the Preface, to meet a real need for a comprehensive atlas of fractures and other joint injuries depicted in such a fashion that the essential characteristics of the lesions are readily recognized and the detailed methods of reduction, immobilization and postreduction management are clearly visualized step by step. In the present era of ever increasing velocity and at a time when the incidence of industrial injuries to the musculoskeletal system is steadily rising, an atlas of this type provides rapid reference for most lesions encountered. In a brief definitive style, the pertinent information relative to each injury is recorded under the heading of "Remarks." It comprises in many instances the peculiarities of the lesion, the associated pathology, the prognosis and the complications, and should be in this compact fashion of particular interest and value to students, residents and practitioners concerned with the treatment of trauma. Recognizing that much controversy exists in the treatment of certain fractures, the author, who is Professor of Orthopedic Surgery at Jefferson Medical College, nevertheless depicts only those methods which in his hands have yielded the most gratifying results. For the sake of completeness the first part of the book is devoted to principles. There, too, only the most pertinent facts are recorded and those contemporary methods of management illustrated which have served best in his hands.

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**Fracture Surgery.** *A Textbook of Common Fractures.* By Henry Milch, M.D., and Robert Austin Milch, M.D., Pp. 470. Illus. 671. Price \$17.50. New York, Paul B. Hoeber, Inc., 1959.

Bridging the gap between the small handbook of fracture management and the encyclopedic volume encompassing material primarily of interest to the specialist, this book is the outcome of the problems confronting the intern or resident in the emergency ward of a large hospital, when the urgent call makes a ready reference work of largely pictorial nature highly desirable. It covers most fracture problems that are likely to arise, providing convenient access to the information required for accurate diagnosis and definitive treatment. In accord with the basic therapeutic principle of aligning the axis of the distal fragment with that of the proximal, fractures are presented in the light of their axial malalignments. Hundreds of fine x-ray plates graphically illuminate the explicit text descriptions. Precise information is easily located, making it an ideal handbook for use in emergencies. Emphasizing the common problems, the book will prove as valuable to the medical student, the surgical house officer and the general practitioner who frequently treats a fracture as a small and unexpected part of practice as to the specialist.

**Practical Dermatology.** By George M. Lewis, M.D., F.A.C.P. Ed. 2. Pp. 363. Illus. 555. Price, \$8.00. Philadelphia, W. B. Saunders Company, 1959.

Appropriately titled, this book offers up-to-date and straightforward advice on the diagnosis and therapy of common dermatoses. Coverage ranges from simple insect bites to the difficult problems of malignant skin tumors. Comprising a virtual atlas of dermatologic diagnosis, the many excellent illustrations simplify the puzzling aspects of diagnosis to a remarkable degree. In addition, the author explains the important features of the history, the general physical examination, the special examination, and the various pertinent laboratory tests, alerting the reader to the systemic or malignant conditions of which a skin manifestation may be the first sign. He presents treatment in detail, giving definite instructions on diet, local measures, ultraviolet therapy, drugs, endocrine therapy, x-ray therapy and whatever measures may be in order for clearing up a particular lesion. Also, he includes advice on managing the emotional causes of skin disorder. This new second edition offers help on the use of corticosteroids, new physical treatments such as skin planing, tattooing, et cetera. Much new material has been added on the collagen diseases, and there is a new chapter on Basic Sciences in Dermatology, which provides a keen insight into the mechanisms of skin disease. The current information on the use of the various wet dressings, powders, ointments and cleansing agents in topical medication is well covered, as are the vitamins, antihistamines and antimicrobial agents for systemic medication.

**Clinical Obstetrics and Gynecology; Volume 1, Number 4, Symposium on Operative Obstetrics,** edited by J. Robert Willson, M.D., and **Symposium on Genital Cancer,** edited by Daniel G. Morton, M.D. December 1958. Pp. 857-1138. Price, \$18.00 by subscription for four consecutive numbers. New York, Paul B. Hoeber, Inc., 1958.

Published four times a year, illustrated and containing over 1,100 pages, Clinical Obstetrics and Gynecology completes its first volume with this number. Outstanding contributors participated in the two symposiums presented here. The Symposium on Operative Obstetrics covered injuries to the vagina and perineum; prevention and management; injuries to the cervix and uterus; prevention and management; management of dystocia due to large or abnormal fetus; breech extraction; forceps delivery; cesarean section; obstetric version; operations to preserve pregnancy; sterilization and therapeutic abortion; and anesthesia and analgesia. The subjects presented in

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the Symposium on Genital Cancer were genital carcinoma: early diagnosis; carcinoma in situ of the uterine cervix; radiation treatment of cervical cancer; radical hysterectomy with bilateral pelvic-lymph-node dissection for cancer of the uterine cervix; radical operation for recurrent gynecologic cancer; the treatment of pelvic malignancies with radioisotopes; endometrial carcinoma: epidemiology, diagnosis, and treatment; the diagnosis and treatment of ovarian carcinoma; carcinoma of the vulva, carcinoma of the vagina, carcinoma of the fallopian tube; and complications of the treatment of pelvic cancer.

**A Textbook of Medicine.** Edited by Russell L. Cecil, M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D., D. Hon. Causa., L.L.D. Pp. 1,665. Illus. 182. Price, single volume \$16.50, two volume set \$20.50. Philadelphia, W. B. Saunders Company, 1959.

In this new tenth edition of a book that has had an important place in the professional library of many thousands of physicians for more than three decades there is presented the most extensive revision the text has yet sustained. One hundred sixty-four American authorities present the important medical developments of the last four years, making this latest edition more useful, more informative, more an integral part of the daily round of clinical medicine than was any previous edition. For practitioners and students alike this highly esteemed medical reference fills the broad picture of today's medicine with the multitude of details needed to understand, diagnose and manage effectively the multiplicity of known disease. Some 800 separate diseases are covered.

Completely integrated and up-dated from first page to last, this presentation of today's collective knowledge on pathophysiology, diagnosis and management of disease contains 38 completely new topics and 91 articles drastically revised; there are 30 eminent new contributors.

There are four members of the faculty of the College of Medicine of the University of Florida among the contributors. These authors and their subjects are: Dr. George T. Harrell, Trichinosis; Dr. Peter F. Regan III, Electric Shock Treatment in Psychiatric Therapy; Dr. Lamar Roberts, Aphasia; and Dr. William White Stead, Simple Hydrothorax; Pleurisy; Pneumothorax; Uncommon Pleural Diseases.

**A Doctor Remembers.** By Edward H. Richardson, M.D. Pp. 252. Price, \$3.95. New York, Vantage Press, 1959.

In this engaging book the author recreates a time in American medicine when practices revered today were being established by the "Big Four" at the Johns Hopkins University School of Medicine. He is one of the few living men who can recall, with fascinating vividness, the famous Four: William H. Welch, William (later Sir William) Osler, William Stewart Halsted, and Howard Atwood Kelly as well as many others. He knew them, studied under them, worked with Halsted and Kelly, and his warmly personal sketches give a memorable picture of the scene as it appeared to a young apprentice "in daily contact with the most competent and stimulating group of medical educators in America." From the kaleidoscopic panorama of a lively boyhood, school days, and 42 years as an active, and 10 additional years as an emeritus, faculty member at the Johns Hopkins School of Medicine, Dr. Richardson has gleaned a rich variety of observations and experiences both intriguing and revealing. As he comments in the Foreword, his human interest story "demonstrates conclusively that an average American lad, even when orphaned early in his childhood, who exercises purposeful and discriminating judgment in grasping the opportunities offered by our free-enterprise system can achieve through perseverance, determination, and sustained hard work a gratifying measure of success in the profession of medicine."

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* Bradford, Gilchrist, Union				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	33
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	67
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	249
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	6
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* Baker				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	968
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	27
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	358
* Clay				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	116
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	242
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	38
* Sumter				
Lee-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-				
Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	80
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Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	9
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Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	181
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	20
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	309
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	133
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Matby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	93
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
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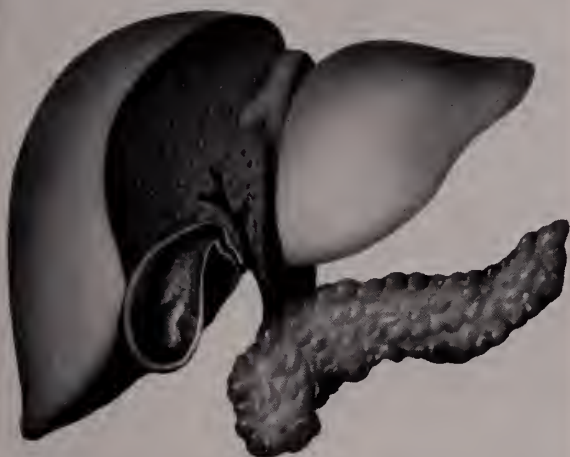
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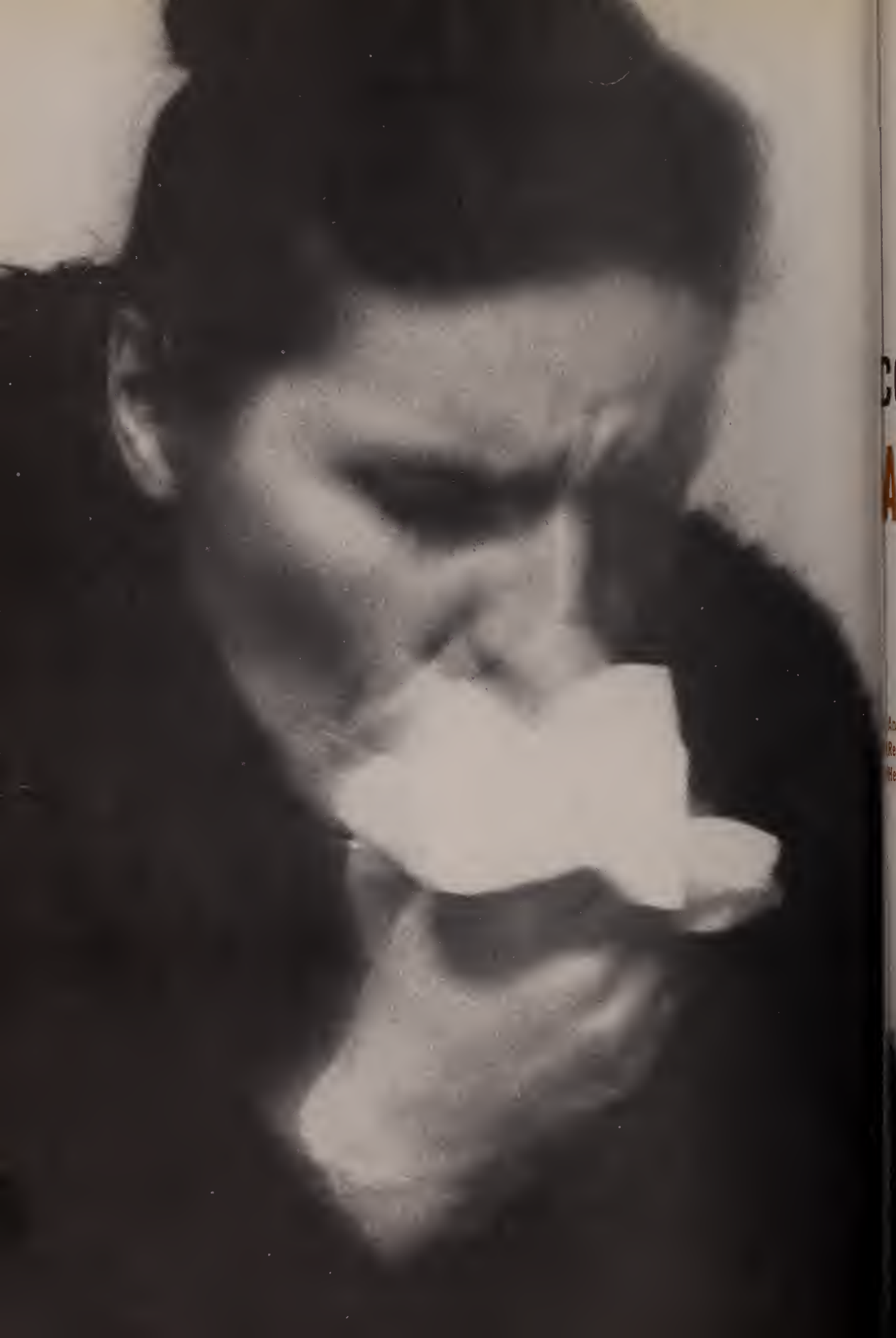
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• December, 1959

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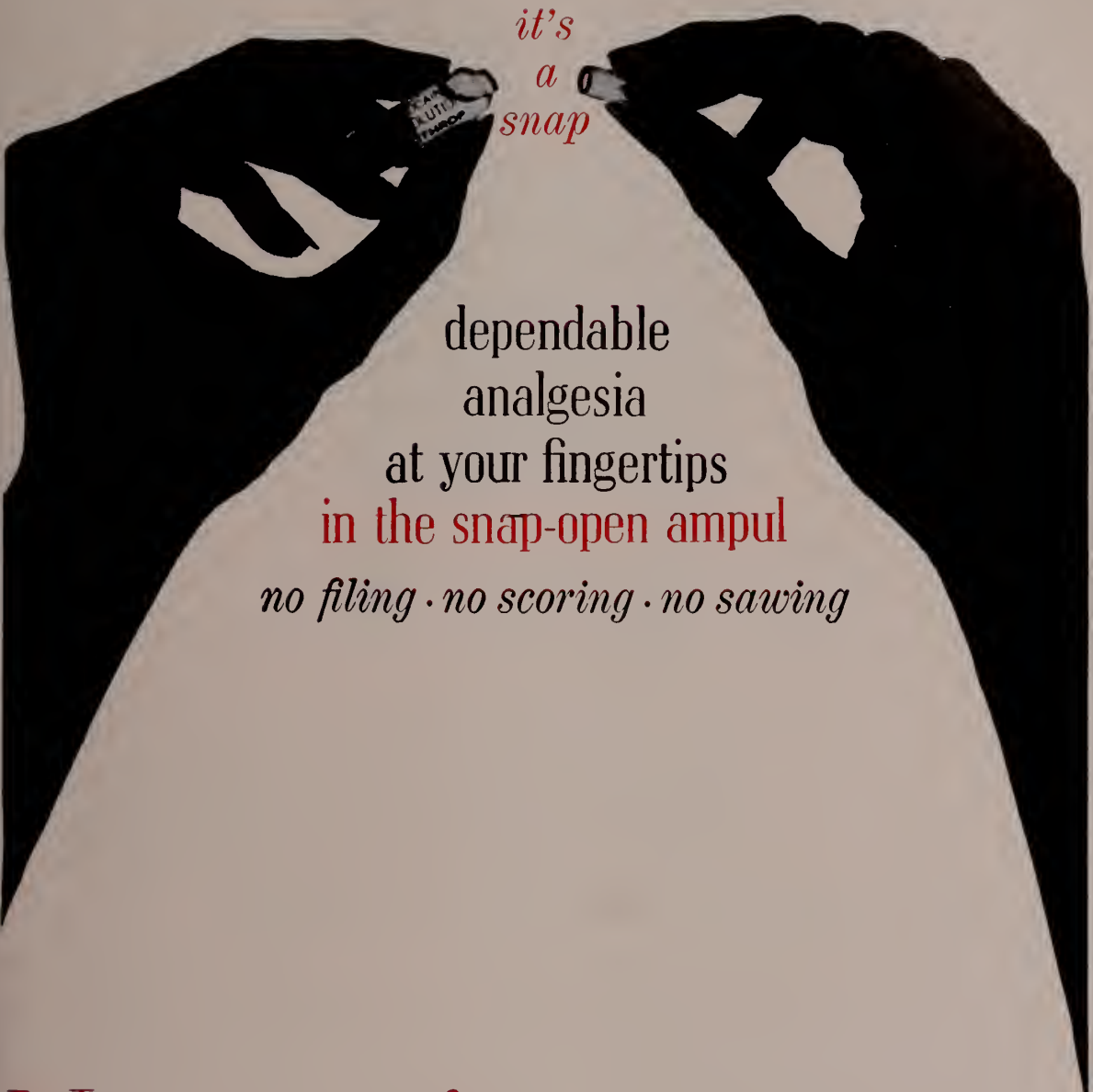
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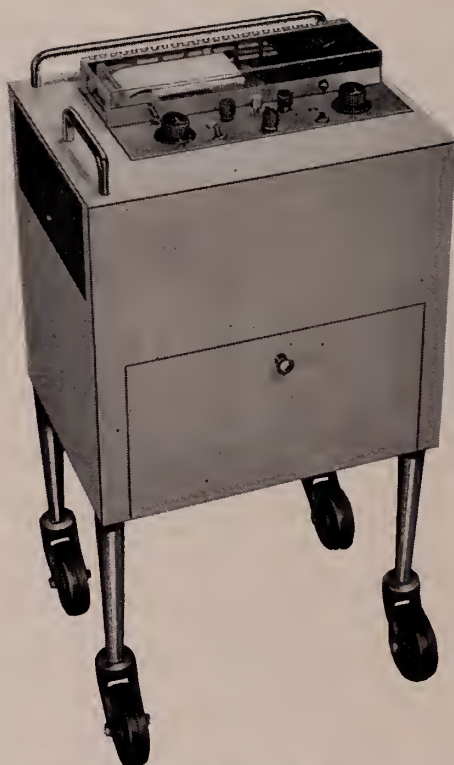
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## Why should I use **KANTREX®** Injection\* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics<sup>3,4,10,12,13,17,18,20,21,23,24,25,27,30,33,35,37</sup>

—organisms such as *Staph. aureus*, *Staph. albus*, *A. aerogenes*, *E. coli*, *H. pertussis*, *K. pneumoniae*, *Neisseria* sp., *Shigella*, *Salmonella* and many strains of *B. proteus*.

*Q But if I use KANTREX Injection, won't that help make bacteria resistant to it also?*

*Next page, please . . . . .*

*Q But if I use KANTREX Injection, won't that help make bacteria resistant to it also?*

*A* A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

*Q My impression is that KANTREX is just another neomycin. Isn't that so?*

*A* Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"<sup>11</sup>; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

*Q You mean that KANTREX Injection doesn't have the nephrotoxicity of neomycin?*

*A* Precisely. It's true that when KANTREX Injection is used, urinary casts — even slight albuminuria or microscopic hematuria — may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

*Q Then why do you recommend reduced dosage in patients with renal impairment?*

*A* Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads

to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

*Q Is that why we see reports of patients developing hearing loss during KANTREX Injection therapy?*

*A* Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function — with minimal risk of ototoxicity.

*Q Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use KANTREX Injection in such conditions?*

*A* Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus*, *A. aerogenes* and *E. coli*, even when renal impairment is present.

*Q What are the "proper precautions" in a patient with impaired renal function?*

*A* The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more



is seldom required because the clinical response to KANTREX Injection is so rapid.

**Q** *Why do you put so much emphasis on KANTREX's "rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

**A** There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.<sup>1,2,3,7,8,9,11,15,16,19,21,22,26,29,32,33</sup> Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."<sup>29</sup>

**Q** *Does KANTREX Injection cause blood dyscrasias?*

**A** In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

**Q** *Can I administer KANTREX Injection in any other way than by the intramuscular route?*

**A** Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

**Q** *So you think I ought to use KANTREX Injection as my first choice antibiotic in staph and gram-negative infections?*

**A** Yes — because all evidence to date indicates that it is bactericidal against a wide range of organisms... rapid acting... does not encourage development of bacterial resistance... is well tolerated in specified dosage... and has not caused any blood dyscrasias.

## KANTREX<sup>®</sup> CAPSULES

*for local gastrointestinal therapy...  
not for systemic infections*

**Q** *Why can't I use KANTREX Capsules for systemic medication?*

**A** Because there is only negligible absorption of KANTREX from the gastrointestinal tract.<sup>3,5,6,8,28,34</sup> Thus, capsules cannot provide effective blood levels.

**Q** *Then what are KANTREX Capsules used for?*

**A** Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

**Q** *I've been using neomycin for preoperative bowel sterilization. Why should I switch to KANTREX Capsules?*

**A** Because KANTREX has been rated as "superior to neomycin" for this purpose.<sup>6</sup> It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.<sup>5,6</sup>

**Q** *What advantages do KANTREX Capsules offer me in the treatment of intestinal infections?*

**A** A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella*, *Shigella*, *Staph. aureus*, *E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."<sup>31</sup>

## INJECTION

KANAMYCIN SULFATE INJECTION

### INDICATIONS

Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives": genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

### DOSAGE: INTRAMUSCULAR ROUTE

Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

### TOXICITY

When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

### OTHER ROUTES OF ADMINISTRATION

KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

### PRECAUTIONS

Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

### SUPPLY

Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

**KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.**

**KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.**

## CAPSULES

(for local gastrointestinal therapy; not for systemic medication)

### INDICATIONS AND DOSAGE

*For preoperative bowel sterilization:* 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

*For intestinal infections:* Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

### PRECAUTION

Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

### SUPPLY

KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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**BIBLIOGRAPHY:** 1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. *J.A.M.A.* 166:1019, March 1, 1958. 2. Bateman, J. C. and Carlton, H. N.: Deprol as adjunctive therapy for patients with advanced cancer. *Antibiotic Med. & Clin. Therapy*. In press, 1959. 3. Bell, J. L., Tauber, H., Santy, A. and Pulito, F.: Treatment of depressive states in office practice. *Dis. Nerv. System* 20:263, June 1959. 4. McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slatery, J. J., Konelaf, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B.: Treatment of depression—New techniques and therapy. *Am. Pract. & Digest Treat.* In press, 1959. 5. Pennington, V. M.: Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. *J. Am. Geriatrics Soc.* 7:656, Aug. 1959. 6. Rickels, K. and Ewing, J. H.: Deprol in depressive conditions. *Dis. Nerv. System* 20:364, (Section One), Aug. 1959. 7. Ruchwarger, A.: Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. *M. Ann. District of Columbia* 28:438, Aug. 1959. 8. Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. *Antibiotic Med. & Clin. Therapy*. In press, 1959.

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**DOSAGE:** Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

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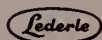
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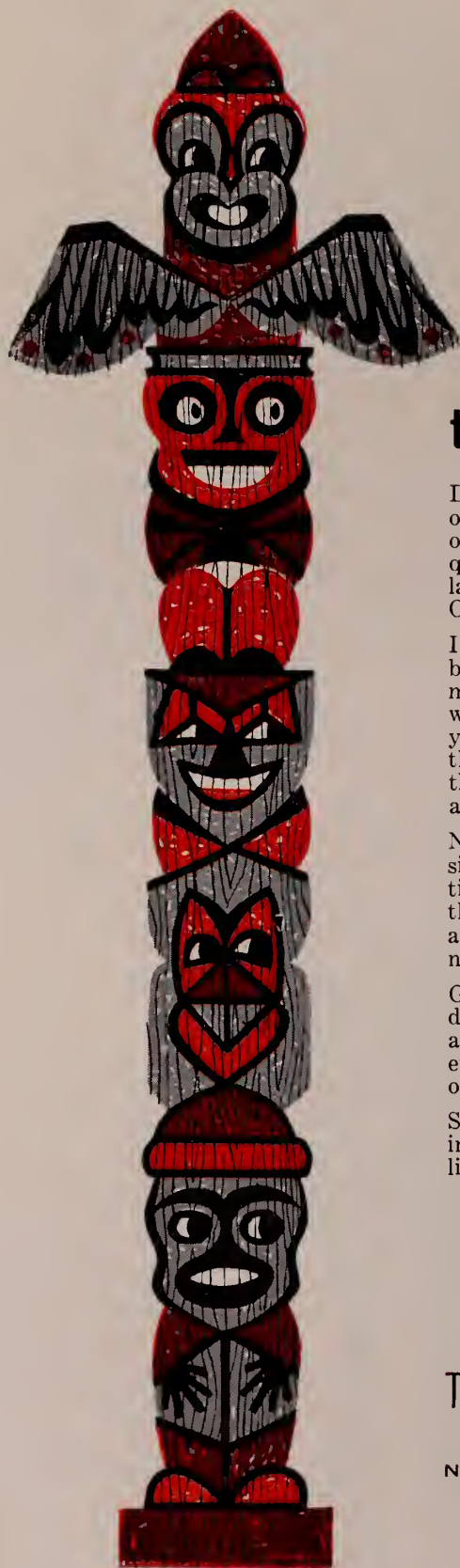
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Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

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*specific for intestinal amebiasis*

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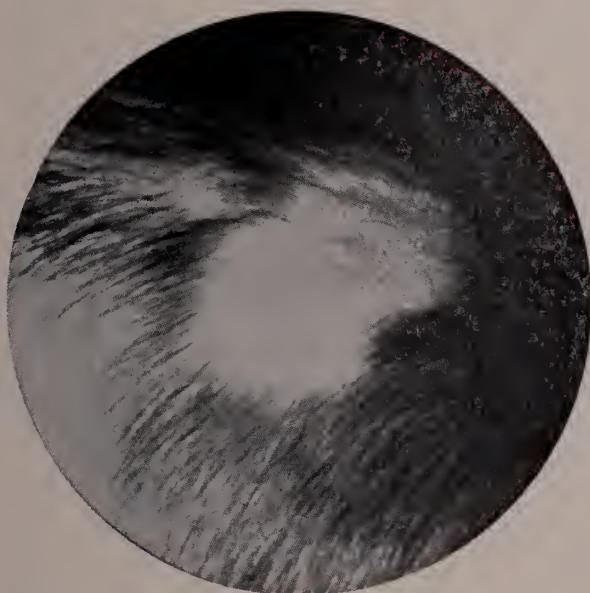


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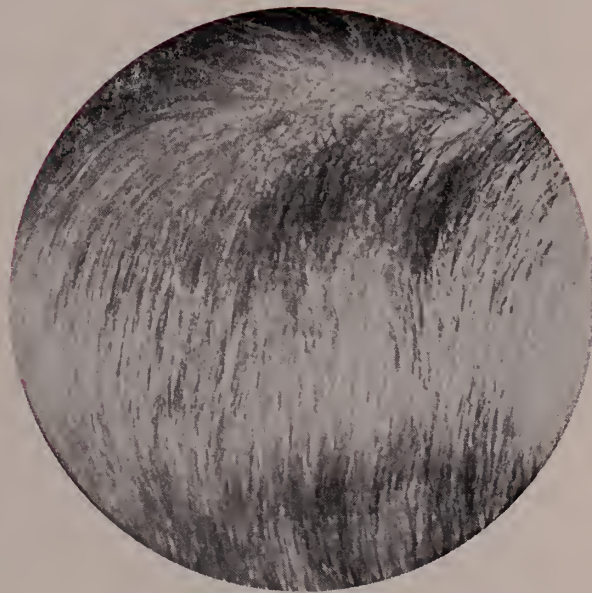
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*After FULVICIN: Normal, new hair growth after 6 weeks of oral therapy.*

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first oral fungistat to penetrate keratin from the inside... acts to check invading ring-worm fungi (*Microsporum*, *Trichophyton*, *Epidermophyton*)...usually well tolerated, side effects rare in therapeutic doses.

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10 to 25 pounds	5 mg. per pound of body weight	} every six hours
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Ilosone<sup>®</sup> Lauryl Sulfate (propionyl erythromycin ester lauryl sulfate, Lilly)



# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 6, December, 1959

## Clinical Variations in Thyrotoxicosis

MILES J. BIELEK, M.D.  
FORT LAUDERDALE

One hundred cases in which radioactive iodine was used in treatment at Broward General Hospital were reviewed. Of this number, 25 were removed from the study because the patients were treated not for thyrotoxicosis but for angina, congestive heart failure and emphysema, or an inadequate history was available.

In the 75 cases to be discussed, the disease was as accurately diagnosed as is possible by confirmation with the newer diagnostic aids, the protein-bound iodine, the radioactive iodine uptake study, and the red blood cell uptake study. Thyrotoxicosis is a disease of protean manifestations, only a few of which may be grouped together at one time, thereby assuming various forms, some of which are difficult to diagnose clinically. If, however, the possibility of thyrotoxicosis is thought of, the diagnosis is not difficult.

This paper, therefore, will stress the more important signs and symptoms. When they occur, thyrotoxicosis must be included in the differential diagnosis, and confirmatory laboratory examinations must be carried out. This disease is an important one to rule out for it is an ailment that is comparatively remediable compared to many other ailments.

### Classification

Table 1 presents a classification of thyrotoxicosis. This has been broken down into (1) diffuse thyrotoxicosis, (2) nodular thyrotoxicosis, and (3) recurrent thyrotoxicosis.

Of the diffuse variety, those cases which were typically thyrotoxic with a diffuse gland and exophthalmos numbered 32, or 42 per cent. Of the atypical group, those which failed to reveal signs

and symptoms that may be regarded as typical were (1) those without exophthalmos but having typical signs and symptoms otherwise, 22 per cent; (2) those without an apparent goiter, but otherwise typical in their signs, symptoms and manifestations, 20 per cent; (3) those which had nodules in a diffusely enlarged gland, and had typical signs and symptoms, 15 per cent; and (4) those which could be classified as malignant exophthalmos, 4 per cent. In reality none of the patients' exophthalmos progressed to loss of vision, but it was severe enough in some instances for one actually to consider decompression. In addition, I have included in this group exophthalmos occurring due to pituitary stimulation but without evidence of hypermetabolism; only one case of this type was seen.

Those that were nodular and typically toxic consisted of a typical nodular group, and secondly, those in which the nodules were present predominantly and toxicity seemed to be present in assessing the uptake of iodine in the nodule; however, true hypermetabolism was not evident. This group led frequently to those that could be classified into thyrocardiac disease in which often congestive heart failure, fibrillation, and dyspnea were the most common signs and symptoms but in which frequently the radioactive iodine uptake and protein-bound iodine were at the upper limit of normal, or just beyond it. It is in this group that the disease is often difficult to diagnose, and yet these patients are the salvagable cardiacs. It should, therefore, be stressed that one should think of thyrocardiac disease whenever dealing with a cardiac patient who is not doing well otherwise. Perhaps it would be well to consider thyroid disease as the etiology of cardiac disease in any case, even when another diagnosis seem-

Table 1.—Classification of Thyrotoxicosis

I. Diffuse	
A. Typical	42%
B. Atypical	
1. Without exophthalmos	22%
2. Without apparent enlargement	20%
3. With nodules	15%
4. Malignant exophthalmos	4%
5. Exophthalmos without hypermetabolism	1%
II. Nodular	
A. Typical	
B. Toxic nodules without hypermetabolism	
C. Thyrocardiac disease	
III. Recurrent Thyrotoxicosis	

Table 2.—Classical Signs and Symptoms of Typical Thyrotoxicosis

FEMALE TO MALE RATIO 4 to 1

Symptoms	Signs
Nervousness	<i>Exophthalmos</i>
Irritability	<i>Goiter</i>
Emotional instability	Tremor
Perspiration	Cardiac failure
Increased activity	Fine warm velvety skin
Loss of weight	Soft silky hair
Weakness	Hyperpigmentation, frequent
Loss of appetite	<i>Eye signs</i>
Anorexia	Stellwag's (infrequent winking)
Nausea	von Graefe's (lid lag)
Vomiting	Möbius' (failure of convergence)
Diarrhea	Sainton's (lateral nystagmus)
Intolerance to heat	Wide pulse pressure
Dyspnea	Tachycardia
Palpitation	Systolic murmurs
Amenorrhea	Cardiac enlargement
Occasional menorrhagia	Poor response to digitalis
	<i>Bruit</i>
	<i>BMR elevated</i>
	<i>Premature graying</i>

ingly is apparent, for thyrotoxicosis may complicate or aggravate other forms of heart disease.

In the third group, recurrent thyrotoxicosis is included merely to be all inclusive, but is not of concern at this time.

Signs and Symptoms

Table 2 lists the signs and symptoms of typical thyrotoxicosis that have been described as classical signs and symptoms of typical thyrotoxicosis in textbooks. The 4:1 ratio of females to males is the same ratio as in the study under consideration. I will not review these symptoms and signs here, but will direct attention later to the absence of some which are considered to be important. The symptoms and signs italicized are the ones which vary in my series of cases.

In table 3 the symptoms are broken down in the frequency of their preponderance in the group of cases under consideration. Nervousness

occurred in almost all. Palpitation or tachycardia was prominent. The latter could be included as a sign for tachycardia was frequently present though patients often complained of palpitation. Loss of weight is a common manifestation; yet it can occur without an increased appetite as is commonly described. In only 37 per cent of the cases was there an increased appetite despite typical textbook descriptions of the typical pattern of thyrotoxicosis. Perspiration and heat intolerance were common; weakness and dyspnea occurred in over 50 per cent of the cases, as did insomnia. Another important symptom occurring in 26 per cent of the cases was a change in bowel habit, often from a normal to a looser stool or frequently to diarrhea.

Table 4 enumerates the important signs and their incidence as noted in this study. Coarse tremor, a fine velvety skin, a wide pulse pressure, and diffuse enlargement were the more common signs. In addition, other important signs included alertness, exophthalmos, quickness of motion and thinning of hair. Certain other coexisting signs were present such as hypertension and congestive failure. I might mention here that eye signs listed as 14 per cent really is a misnomer for the typical eye signs, such as Möbius' sign and von Graefe's sign, occurred actually only in 2 or 3 per cent of the patients. This statement "eye signs 14%" really should be placed under symptoms for the patients' complaints were blurring of vision and double vision, rather than actually showing evidence of eye signs. Perhaps, because I am about to convert to bifocals, I do not have the necessary vision to detect eye signs as some writers have described in the textbooks. I believe, however, that if one cannot elicit signs readily, then it would be best to delete them from the thinking regarding diseases, and in many instances textbook descriptions are "hand-me-down" descriptions of signs whereas when one actually studies a group of patients such as reported here, he finds how little value the eye signs have.

Congestive failure with poor response to digitalis, fibrillation, and a brittleness of diabetes frequently point out that thyrotoxicosis could be the underlying cause. Whenever these occur, one should always think of thyrotoxicosis.

Nodules were present in 13 per cent of the patients. I am speaking of nodules that were separate from a diffuse enlargement, though this state is, of course, somewhat difficult to evaluate. Other signs noted were pretibial edema, a single

nodule occurring in only 2 per cent and a unilateral stare occurring in only one patient. When the unilateral stare is present, however, it is almost pathognomonic.

### Associated Diseases

In table 5 are enumerated the diseases associated with thyrotoxicosis. Frequently, thyrotoxicosis may be a precipitating factor in poor control of other diseases and it is often associated with hypertension, congestive failure, coronary artery disease with angina, particularly in the patients studied who were in an elderly age group, diabetes uncontrolled or brittle, and rheumatic heart disease where consideration of active rheumatic activity or subacute bacterial endocarditis were considered. Nervous breakdowns occurred in 3 to 4 per cent of cases, and coincidental were peptic ulcer and a number of other illnesses which accounted for the remainder of 1 per cent each.

A point of interest was noted in that frequently thyrotoxicosis occurred in persons who reported endocrine disturbances in other members of the family, thereby showing that perhaps there may be a hereditary basis. In 8 per cent of the cases, diabetes was present in others in the family, and likewise, hypothyroidism, goiter, and acromegaly were present in more than enough to be a statistical coincidence.

### Other Significant Observations

Another significant observation emerged from the study in that in 4 per cent of the cases in the series the basal metabolic rate was normal. This test is being used less and less, and I heartily recommend that it not be used at all in order to avoid further expense to the patient for the poor value received. This is a high value rather than a low one simply because the basal metabolic rate was determined on only eight patients so that the corrected figure is over 50 per cent. In addition, the blood cholesterol frequently correlated and when it did, was a confirmatory finding. The correlation, however, was extremely poor because the cholesterol value is not obtained too frequently. It should be determined before each treatment is given so that one can use it as a guide to further treatment and response. The cholesterol value was low in only 12 per cent of cases confirming the diagnosis. In all fairness, however, the cholesterol determination was carried out in only 20 cases. The corrected figure therefore is 50 per cent.

The pigmented or salmon-colored skin spoken of in textbooks was not seen in any of the patients in this series, and I believe it can be forgotten. It probably, too, is a handed-down myth; maybe it occurred in a few olive-skinned persons coincidentally at one time and has been appearing in textbooks ever since. It is also of importance that 8 per cent of the patients had previously taken thyroid, and that in 9 per cent there was a family history of hyperthyroidism. Premature graying as has been described in textbooks also was not a consistent finding, and I would recommend that this sign be dropped from one's thinking.

**Table 3.—Frequency of Symptoms in Series Reported**

Symptom	Number	Per Cent
Nervousness .....	72	96
Palpitation (or tachycardia) .....	58	77
Loss of weight .....	60	66
Heat intolerance .....	49	65
Perspiration .....	48	64
Weakness .....	43	57
Dyspnea .....	40	53
Insomnia .....	39	52
Increased appetite .....	28	37
Looser stool .....	20	26

**Table 4.—Signs and Their Incidence in Series Reported**

Sign	Number	Per Cent
Tremor .....	65	86
Fine skin .....	55	73
Wide pulse pressure .....	55	73
Diffuse enlargement .....	48	64
Alertness .....	33	44
Exophthalmos .....	32	42
Quickness of motion .....	26	34
Thinning of hair .....	21	28
Hypertension .....	20	26
Congestive failure .....	17	22
Eye signs .....	11	14
Congestive failure with poor response to digitalis .....	11	14
Nodules .....	10	13
Fibrillation .....	9	12
Brittle diabetes .....	7	9
Pretibial edema .....	4	5
Single nodule .....	2	2
Unilateral stare .....	1	1

**Table 5.—Association With Other Diseases**

Disease	Number	Per Cent
Hypertension .....	20	26
Congestive failure .....	17	22
Angina (coronary artery disease) .....	14	18
Diabetes .....	7	9
Rheumatic heart disease .....	5	6
"Nervous breakdown" .....	3	4
Peptic ulcer .....	2	3
Others .....	All	1



Exophthalmos can occur without thyrotoxicosis. It may be familial, it may be present in uremia, and it may be present in hyperpituitarism in one form or another without actual thyrotoxicosis. Do not, therefore, wait until the patient has exophthalmos before considering the diagnosis. The textbooks also mention that toxicosis without goiter is present in about 10 per cent of cases, and in this series, toxicosis without goiter occurred in 20 per cent, a somewhat higher figure. I believe some patients are being seen who have a retrosternal goiter or an enlargement which is undetectable unless one is actually thinking of it and gets lateral chest roentgenograms expressly for the purpose of making this diagnosis.

Once again, let me emphasize that one of the most important diagnostic aspects of thyrotoxicosis is the masked thyrocardiac disease in which transient or permanent fibrillation may occur. The patients may or may not have the classical signs or symptoms as described for thyrotoxicosis; they may have a transient glycosuria; they may have an accentuated first heart sound with a systolic thrill, and fail to respond to digitalis properly. Their circulation time is decreased, and this is a test which could be used more frequently to differentiate this condition. In many instances the heart rate may be normal, and yet thyrotoxic heart disease may be present.

Finally, let me emphasize that thyrotoxicosis is a disease of protean manifestations, and if any of the signs or symptoms enumerated herein are observed in any patient, thyrotoxicosis must be included in the differential diagnosis.

837 Northeast Twentieth Avenue.

### Discussion

DR. WILLIAM A. ABELove, Miami: Allow me to congratulate Dr. Bielek on his analysis of hyperthyroidism and its associated symptomatology.

At the Endocrine Clinic of the Jackson Memorial Hospital, we have followed the course of this disease in some 130 patients over the past three and one-half years. Our classification of hyperthyroidism (table 1) consists of two types: (1) Diffuse toxic goiter (Graves' triad of exophthalmos, goiter and clinical hyperthyroidism); and (2) Toxic nodular goiter.

### Classification of Hyperthyroidism

1. Diffuse Toxic Goiter  
(Graves' disease, exophthalmic goiter)  
Triad of exophthalmos, goiter and clinical hyperthyroidism.
2. Toxic Nodular Goiter

Table 2 serves to differentiate the two clinical types, the diffuse toxic goiter occurring in the younger age group (20 to 40 years), usually in the ratio of four females to one male, with exophthalmos, eye signs, extreme nervousness, increased appetite, weight loss, increased sweating, heat intolerance, palpitations, et cetera, as common associated symptoms. On the other hand, the toxic adenoma is a disease of the over 40 age group. A single or multinodular goiter may be present; exophthalmos is rare, and eye signs are less common. Because of the older age and greater tendency toward degenerative vascular disease, it is in this age group that the presenting symptom may be cardiac (atrial fibrillation, cardiac decompensation).

Clinical Symptoms of Value in Differentiating Types of Hyperthyroidism

	<u>Diffuse Toxic Goiter</u>	<u>Toxic Adenoma</u>
Age	20-40	over 40
Gland	diffusely enlarged	irregular, nodular
Exophthalmos	commonly present	absent
Eye Signs	common	less common
Emotional Symptoms	marked	minimal
Tachycardia	present	present
Atrial Fibrillation	rare	common
Apathy	rare	uncommon

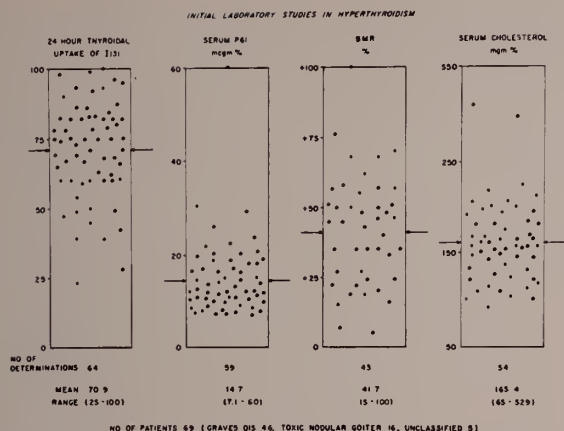
Our impressions concerning the eye signs of hyperthyroidism are somewhat at variance with those of Dr. Bielek. Table 3 lists the types of eye signs as those of the lid, external changes in the lids and the eyes, extraocular palsies and ptoses and exophthalmos. In Graves' disease there is a high incidence of exophthalmos. Exophthalmos and extraocular palsies and ptoses are exclusively related to the occurrence of Graves' disease, the latter being much less common. In Graves' disease additional eye signs are noted frequently. These are widened palpebral fissures, lid lag, infrequent blinking, weakness of convergence, et cetera, and may be the results of the exophthalmos. Thyrotoxic myopathy, on the other hand, occurs as a result of the effects of thyroxin on skeletal muscle and can be seen in both forms of hyperthyroidism. Its signs are usually associated with the lid.

### Eye Signs of Hyperthyroidism

- A. Lid Signs  
(occur either in diffuse or nodular glands)
  1. Widening of palpebral fissure on fixation (Dalrymple)
  2. Lid lag (Von Graefe's)
  3. Infrequent blinking (Stellwag)
  4. Absence of gaze (Jeffroy)
  5. Tremor of closed lid (Rosenbach)
  6. Difficulty in eversion of lid (Gifford)
- B. External Changes in the Lids and Eyes  
(more frequently in diffuse goiter)
  1. Weakness of convergence (Moebius)
  2. Pigmentation of skin of lids (Jellinek)
  3. Excessive lacrimation
- C. Extraocular Palsies and Ptoses  
(rare) less than 1% (exclusively with Graves' disease)
  1. Single or multiple extraocular palsies associated with exophthalmos and severe thyrotoxicosis (improve after therapy)
  2. Those associated with malignant exophthalmos.
- D. Exophthalmos  
over 50% of those with diffuse toxic goiter  
(exclusively with Graves' disease)

Dr. Bielek's review of variations emphasizes the fact that every symptom or sign of hyperthyroidism is not necessary to make the diagnosis; but rather, one must be alerted to the possibility of hyperthyroidism by the clinical picture even in the absence of specific symptoms or signs.

Figure 1 reviews the initial laboratory studies in the first 69 of our cases. Note the variations and the means. The 24 hour uptake of radioactive iodine varied from 23 per cent in one patient to 100 per cent in another



with the mean being 70.9 per cent; protein-bound iodine from 7.1 mcgm. per cent to 60 mcgm. per cent (the latter probably spurious) with a mean of 14.7 mcgm. per cent; basal metabolic rate from plus 5 to 100 with a mean of 41.7; the cholesterol from 83 mgms. per cent to 329 mgms. per cent with a low normal mean of 163.4 mgms. per cent. The protein-bound iodine test in our hands has been the most reliable of all thyroid function tests.

These figures indicate the importance of a careful clinical evaluation and the necessity often for more than one laboratory diagnostic procedure as confirmatory evidence of hyperthyroidism.

DR. SAMUEL W. ROOT, Jacksonville: Dr. Bielek's interesting paper underlines several points which are worthy of re-emphasis. It is certainly worth while to be reminded of the significant as well as the less obvious signs and symptoms whereby hyperthyroidism may be detected. It is a serious omission if one overlooks a treatable form of heart disease, as is so well brought out by Dr. Bielek. Unexplained auricular fibrillation should always bring up the question of thyrotoxicosis.

In a series of 108 cases in which hyperthyroid patients were treated over the past four years with I<sup>131</sup> in Jacksonville, the incidence of some signs and symptoms was at variance with that in Dr. Bielek's cases. The differences were as follows: 1. In only three or four cases the thyroid was not palpable. There were in addition to these cases several cases of postoperative recurrence in which one could not distinguish definite thyroid tissue because of fibrosis. Only 3 or 4 per cent, however, had nonpalpable thyroids. 2. A fine tremor was present in many cases instead of a coarse tremor, and seemed more prevalent than a coarse tremor. 3. Eye signs, and I

mean by these stare, conjunctival edema, lid lag and exophthalmos, were present in a large percentage of the cases, but as in Dr. Bielek's study there were some with no eye signs at all. I would, however, list eye signs as a prominent feature. 4. Thinning of the hair was not looked for in our series, but will be in the future. I have seen three cases, all in females, of hair thinning after treatment with I<sup>131</sup>; fortunately this was self-limited, and in all cases the hair grew back without any harm being done.

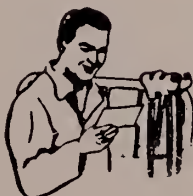
Points of correlation among the rarer signs were: 1. Pretibial edema; localized myxedema in two cases, or about 2 per cent; Dr. Bielek's series, 5 per cent. 2. Unilateral exophthalmos in one case, or 1 per cent; Dr. Bielek's series, 1 per cent. 3. Single nodule in one case, or 1 per cent; Dr. Bielek's series, 2 per cent. 4. Progressive exophthalmos in one case, or 1 per cent; Dr. Bielek's series, 4 per cent.

I enjoyed Dr. Bielek's paper and would like to ask him one question in relation to exophthalmos, and that is whether he thinks that he would rather treat a hyperthyroid patient who presents himself with prominent eye signs with I<sup>131</sup>, or surgery, or propylthiouracil.

DR. BIELEK, closing: Thank you, Dr. Abelow and Dr. Root, for your discussion.

First, I will answer Dr. Root's question as to whether one would treat a patient with exophthalmos with radioactive iodine, propylthiouracil, or surgery. I have not had enough actual experience in following some of the surgical patients; however, I am under the impression that patients with exophthalmos do better under treatment with radioactive iodine. Possibly they might be treated with propylthiouracil first and for several weeks after receiving the radioactive iodine therapy to effect a better result as far as the eyes are concerned. Certainly one sees progression of malignant exophthalmos following surgery as well as following therapy with radioactive iodine. My impression is that following treatment with radioactive iodine, one is less apt to have as great progression.

In regard to the differences stated in our studies regarding eye signs, they perhaps might be due to the fact that our patients were all patients who were coming up for consideration of treatment with radioactive iodine. We, therefore, saw very few of the younger age group, and possibly that might make a difference in our diminished incidence of so-called Graves' disease as compared to yours. The remark of Dr. Root's on the thinning of the hair, post-therapeutically, is a most interesting one; I have not noticed it, but certainly shall be watching for it in the future. Tremor, I agree, is a common finding, and practically all the patients had it; however, their symptoms of nervousness were even more in increased frequency.



# Medical Management of Heart Disease In Pregnancy

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At present, for practical purposes, heart disease in pregnancy means mitral stenosis. Reviewers of this subject consistently report that in approximately 90 per cent of the patients disease of the mitral valve is due to inactive rheumatic fever.<sup>1-5</sup> There are good reasons to anticipate, however, that this predominance will soon be changing.

The first reason is that the incidence of rheumatic fever is decreasing, because of better and earlier diagnosis and more effective treatment. Prolonged oral prophylactic administration of penicillin, for example, has shown great promise for this purpose. Systematic case finding of streptococcal sore throats, such as those reported in the Casper, Wyoming, study,<sup>6,7</sup> may lead soon to finding rheumatic fever a vanishing disease. Then of those patients in whom rheumatic carditis and eventual mitral stenosis still develop, most who are symptomatic will more often have surgical correction before marriage and pregnancy.

Another reason for a percentile decrease of rheumatic heart disease in pregnant cardiac patients is the actual (as well as relative) increase in patients with congenital heart disease who survive to the age of pregnancy. Although a great share of credit for this increased survival belongs to the cardiac surgeons, since lesions such as tetralogy of Fallot are now in some cases being completely corrected, unsung heroes in this gratifying conquest are the pediatricians, who are providing better care for children with congenital heart disease. A notable example is the diminishing incidence of bacterial endocarditis in such patients.

Like statistics on the types of heart disease encountered in pregnancy, which are changing, statistics on frequency of complications in pregnant cardiac patients are useful only within certain limits. For example, they may be useful in

assessing the value of a *particular* type of treatment in a specific *single* cardiac disease in pregnancy, but to analyze morbidity and mortality for all cases of heart disease in pregnancy can be misleading. The prognosis for a pregnant patient with mitral stenosis depends less on how other pregnant patients with mitral stenosis fared in general than on the following points in this particular single patient. Has she ever had congestive heart failure? Have previous pregnancies been completed successfully? When did she last have active rheumatic fever? How cooperative and intelligent is she? Are other valves besides mitral involved? Does she have any associated non-cardiac disease, such as anemia or tuberculosis?

Statistics regarding congenital heart diseases are even more deceptive. How can one possibly compare, for example, the prognosis in a pregnant patient with asymptomatic patent ductus arteriosus with that of a patient with cyanotic decompensation due to tetralogy of Fallot? Even in patients with the same disease the prognosis must be qualified. For example, it is much better in the pregnant patient with only slight aortic coarctation and little or no hypertension than in the one with coarctation of the aorta and hypertension, left ventricular hypertrophy and even associated cardiac anomalies.

A sounder approach to the understanding of heart disease in pregnancy is first to know the physiologic cardiovascular changes in normal pregnancy. With this knowledge, and knowing the hemodynamic effects of a specific type of heart disease, one can then anticipate the peculiarities of the effect of pregnancy on that specific type of heart disease.

There are a number of excellent articles on cardiovascular physiology in normal pregnancy, especially those of Hamilton,<sup>8</sup> Burwell and Metcalfe,<sup>1</sup> Adams,<sup>9</sup> Werkö<sup>10</sup> and Rubin.<sup>11</sup> Although the physiologic changes are interrelated, they are best considered separately with the interrelationships described when pertinent.

Read before the Postgraduate Obstetric-Pediatric Seminar, Daytona Beach, Fla., Sept. 9, 1958.

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CARDIAC OUTPUT increases with pregnancy, rising rapidly from the end of the first trimester to a peak at about the end of the seventh month, thereafter diminishing until it returns to the original nonpregnancy levels shortly before term (fig. 1). The amount of increase in cardiac output reaches a maximum of between 25 and 50 per cent. Two factors that influence cardiac output in pregnancy are (1) arteriovenous shunting and (2) peripheral vasodilatation. Because of increased cardiac output the circulation time becomes more rapid. Immediately after delivery the cardiac output, which has returned to normal at term, rapidly rises again by about 30 per cent (owing largely to changes in blood volume at parturition, which will be discussed later), and then recedes to normal gradually during the first two weeks postpartum.

BLOOD PRESSURE changes are the same as those that occur in high cardiac output due to other causes, such as thyrotoxicosis and beriberi. The systolic level stays the same or rises slightly whereas the diastolic level falls, producing a widened pulse pressure. Causes for these changes are increased heart rate, increased blood volume, placental (and other) arteriovenous shunt, decreased peripheral resistance, increased oxygen consumption and increased renal blood flow. The arteriovenous shunting outside the placenta is related to peripheral vasodilatation, which probably occurs as a result of increased progesterone and other hormonal levels; cutaneous spiders and certain "hot" varicosities of pregnancy<sup>12</sup> are examples of this effect. At the time of labor and delivery there is a tremendous increase in blood pressure, a factor of particular importance in caring for the pregnant patient with hypertension.

BLOOD VOLUME increases progressively from the end of the first trimester to near the middle of the third trimester (fig. 2). Some of the reasons for this change are increased oxygen demand, sodium retention and shunting. Sodium retention is influenced by changes in renal blood flow as well as by hormonal changes, both ovarian and pituitary. The plasma volume increase is about twice that in total red blood cell mass, so that results of the peripheral blood examination falsely suggest anemia. The blood viscosity is, of course, decreased. In the last trimester the expanded blood volume does not change much, although there is evidence that it decreases slightly.

At delivery and during the first few days postpartum there are rapid, extensive changes in blood

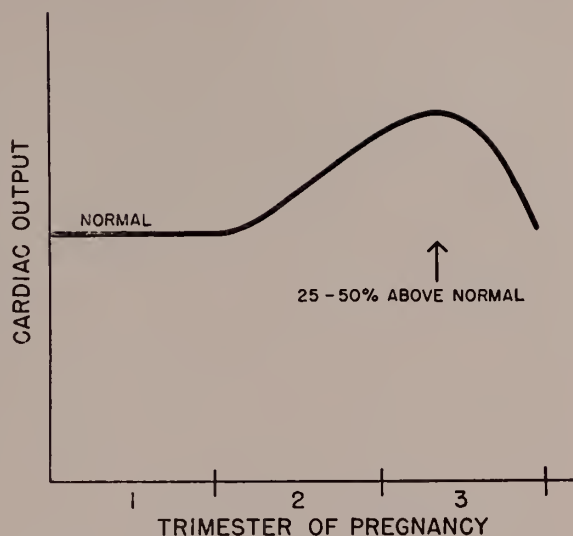


Fig. 1. — Cardiac output in pregnancy.

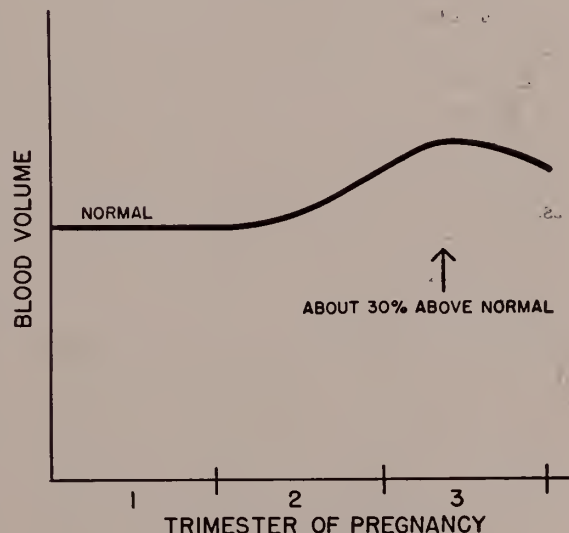


Fig. 2. — Blood volume in pregnancy.

volume and, secondarily, cardiac output (fig. 3). The abrupt decrease in the expanded volume at delivery is much more than can be accounted for by external blood loss alone, often amounting to as much as a liter. Within the first day postpartum, however, this loss is rapidly regained and then is followed by gradual diminution coincident with enhanced diuresis, the blood volume returning to prepregnancy levels at the end of about two weeks.

These rapid shifts in blood volume are taxing to the heart. Not all of their mechanisms are understood, but the initial contraction of volume at delivery is at least related to visible blood loss,

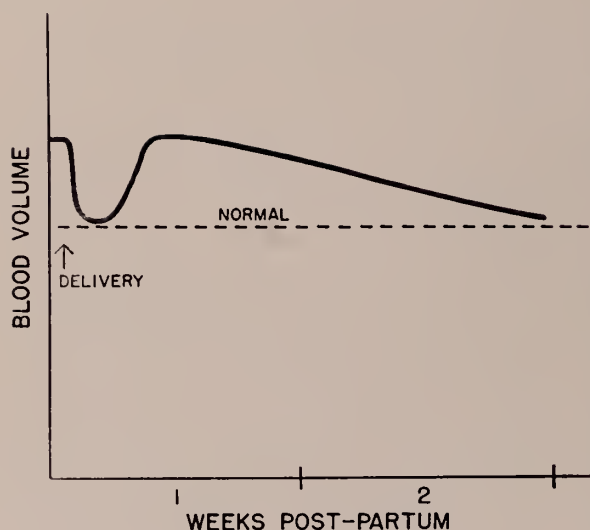


Fig 3.—Blood volume changes after delivery.

nonvisible blood loss, and transudation and exudation into the placental bed. Some reasons for the subsequent rise in blood volume are use of oxytocic drugs, contraction of ovarian veins and loss of placental sinuses. A major pool of blood during pregnancy, the ovarian veins,<sup>13</sup> have been described as acting like a sponge, which becomes squeezed at delivery and empties a large volume of previously sequestered blood back into the general circulation.

Alterations in blood volume during gestation are partly responsible, along with increased cardiac output and decreased blood viscosity, for the frequent appearance of functional systolic murmurs, audible both at the apex and over the pulmonary areas. It is interesting that venous pressure is not generally increased, the increased blood volume being compensated for by vasodilatation plus utilization of depots like the ovarian veins and placental sinuses. Venous pressure in the legs is increased, but this is thought to be due to mechanical impairment of flow.

BLOOD ELECTROLYTE AND HORMONAL CHANGES are dependent on each other and will be discussed together. The immense increase in progesterone levels may enhance sodium excretion, a fortuitous occurrence, since it has been recently demonstrated that pregnancy is normally associated with increased aldosterone excretion.<sup>14</sup> Except for such a balance the powerful sodium-retaining effect of aldosterone would be a problem. The explanation is not as simple as a progesterone-aldosterone antagonism, however, since it has been shown that disproportionately increased levels of aldosterone

in some pregnant women are not associated with increased sodium retention. Thus, the pregnant patient may be relatively resistant to the normal effect of aldosterone, or she may have opposing hormones, one of which may be progesterone.

Other corticoids besides aldosterone are also increased in pregnancy. Their effect in ameliorating certain diseases during pregnancy, such as rheumatoid arthritis, is well known; similarly, Burwell<sup>15</sup> stated he had never seen active rheumatic fever in pregnancy. The abrupt termination of this endocrine plethora at delivery may be responsible for a number of postpartal problems. For example, exacerbations of rheumatoid arthritis at this time, often attributed to streptococcal parametritis, may just as logically be due to loss of previously protecting progesterone. Postpartal "myocardosis" may be due to loss of hormonal protection from an underlying myocardial disorder which may have been present, but suppressed, throughout pregnancy.

The effect of corticoids and possibly other maternal hormones, plus the fetal demand, is likely the basis of bone softening and certain dental problems due to calcium deficiency. This negative calcium balance, calculated against the effect of oral administration of calcium, which is so commonly prescribed, may be troublesome in planning the response and dosage of digitalis in the pregnant cardiac patient, since the relationship of digitalis to blood calcium and potassium levels is well recognized.

VITAL CAPACITY during pregnancy, contrary to popular belief, remains normal. Although the level of the diaphragms may be raised slightly, the increased abdominal contents offer increased resistance to normal diaphragmatic excursion and improve the efficiency of breathing. Additionally, the lateral costal margins become flared outward so that intrathoracic volume may be decreased in a vertical direction, but is increased in a lateral direction. Whatever the exact mechanisms, the well established fact that vital capacity remains normal makes it most important to explain any observed decrease in vital capacity during pregnancy, especially in cardiac patients, since this may be the first evidence of congestive failure.

OXYGEN CONSUMPTION normally rises progressively from the end of the first trimester to a peak of about 15 per cent over nonpregnant levels at term. This rise is a reflection of increased demands of both maternal and fetal tissues. It is a

point to consider in advising pregnant cardiac patients who plan travel to higher altitudes.

PULMONARY BLOOD PRESSURE may or may not change during pregnancy in patients with normal hearts,<sup>4,10</sup> but in patients with valvular obstruction on the left side of the heart impeding filling (mitral stenosis) or emptying (aortic stenosis) the pulmonary blood pressure is consistently raised.<sup>15</sup> The increased cardiac output and blood volume, when opposed by stenotic valves, adequately explain the pulmonary hypertension, but other factors are probably involved.

BACTEREMIA is so common a daily event in all our lives that it may almost be considered normal. It has been demonstrated that simple activities like chewing increase the degree of this phenomenon, especially if there is associated dental infection.<sup>16</sup> During pregnancy such maneuvers as pelvic examination are undoubtedly associated with bacteremia, and delivery even more so. In most women the normal antibacterial defenses quickly and efficiently control this occurrence, but in the pregnant cardiac patient, with vulnerable endothelial surfaces, bacterial endocarditis is a constant danger that must be watched for.

### Therapy

Burwell,<sup>1,15</sup> whose experiences in the care of pregnant cardiac patients can serve as an ideal model, believed that there are rarely if ever indications for cardiac surgery during pregnancy. Wade, Nicholson and Jones<sup>17</sup> recently criticized this attitude, indicating that more of these women with operable lesions should be treated surgically. A moderate attitude on this question must concede that with the quality of care Burwell and his co-workers provide at the Boston Lying-In Hospital, operation is indeed rarely necessary, but it is difficult for most physicians to provide this elegantly organized type of team care. On the other hand, one must not be tempted into the illogical conclusion that because a pregnant cardiac patient can be operated upon successfully she should be. The old axiom that if a patient is well enough to become pregnant, she is well enough to tolerate nine months of pregnancy and vaginal delivery has only rare exceptions. Thus, most pregnant patients with heart disease should be treated conservatively, and if operation is advisable, it should be performed before pregnancy occurs or after delivery.

The question of operation naturally leads one to the consideration of cesarean section. For virtually all patients with cardiac diseases vaginal

delivery is now believed to be preferable, and section should be performed only for obstetric reasons. Even patients with the former exceptions to this rule, such as hypertensive heart disease and coarctation of the aorta, are now believed to be able to tolerate vaginal delivery well.

Certain measures are applicable to any pregnant patient with heart disease. These, as well as specific measures, can be planned intelligently only with a complete understanding of the physiologic cardiovascular changes that normally occur in pregnancy. Thus, it is not inappropriate to emphasize that one of the first measures in treating the pregnant cardiac patient is for her physician to review these changes.

Extra rest is the most important ingredient in the successful therapeutic program for the pregnant cardiac patient. This should include both physical and emotional rest, since superfluous effort in either of these fashions taxes the heart. The best method of achieving this rest must be planned individually by each patient with her physician.

In addition to rest, other measures which can lessen the work of the heart are prompt treatment of such conditions as infections, anemia and thyroid disease; sensible living; frequent antepartum observation, and maximal assistance at delivery. Use of low forceps during the second stage of labor can measurably decrease the physical effort of the mother. Local or regional anesthesia is probably less likely to cause cardiac difficulties than general, if the blood pressure is maintained at the normal level. After delivery oxytocics should be avoided if possible, and given intramuscularly rather than intravenously, in small doses, only when necessary. Their use not only raises blood pressure, but hastens mobilization of previously pooled blood from the uterus and other depots.

Pregnant patients with heart disease must be observed often and carefully, Hamilton and Thompson's warning that "any cardiac may fail at any time" always being kept in mind.<sup>18</sup> These patients should be seen at least every two weeks in the first trimester of pregnancy and every week thereafter. It is recommended that they be under the supervision of both an obstetrician and a cardiologist.

At the earliest sign of congestive heart failure these women should be hospitalized and kept in the hospital until two weeks after delivery. This bitter advice must be discussed with the patient



early in the pregnancy, in order to assure her cooperation. In some cases this ideal program may be impossible for economic or other reasons, but both the patient and her physician must realize that any other course is a compromise with the ideal and more likely to lead to complications. If the heart failure can be proved to be due to a transient event, such as a minor infection which responds readily to treatment, compromise for a shorter period in the hospital may be reasonable.

It is in patients who cannot remain in the hospital for prolonged medical care that a strong argument for surgical care can be presented. The patient with mitral stenosis, for example, who first has mild heart failure in the first trimester and cannot stay in the hospital indefinitely, may do better with commissurotomy.

Congestive heart failure is the most commonly encountered grave complication in the pregnant patient with heart disease, and the commonest cause of death. Necessity for its vigorous, prolonged treatment cannot be overemphasized. In addition to bed rest, the usual measures are employed, such as digitalis, diuretics and salt restriction. Regarding diuretics, especially chlorothiazide, one must keep in mind that hypokalemia is poorly tolerated by patients with limited hepatic reserve and may result in the development of hepatic failure in pregnant patients. Additionally, the severe kaliuretic effect of chlorothiazide predisposes these patients to digitalis intoxication.

The major problem associated with infection during pregnancy is bacterial endocarditis. Next to congestive heart failure the commonest cause of death in pregnant cardiac patients is bacterial endocarditis, though this has diminished since the introduction of antibiotics. The congestive heart failure that develops in some of these patients may be due to myocarditis related to systemic infections, such as viral respiratory infections.

Since rheumatic fever rarely becomes activated during pregnancy, continuing prophylaxis with penicillin during pregnancy is probably not warranted. Such therapy certainly does not obviate development of bacterial endocarditis and may be falsely reassuring to the physician in this respect. There is even suggestive evidence that prolonged penicillin therapy predisposes to infection with resistant staphylococci.

Although antibiotic prophylaxis is of doubtful value in noncardiac patients,<sup>19</sup> in the pregnant cardiac patient it is advisable at certain times.

For a few days preceding and after delivery, or any dental procedure, antibiotics should be administered in an effort to diminish the bacteremia. It must be realized, however, that they do not prevent it, and that endocarditis may still result though this is probably less likely. For this purpose the simultaneous use of penicillin and streptomycin is at present without parallel. Penicillin alone is much less effective because of the common presence of enterococci or gram-negative organisms in the pregnant patient. Use of bacteriostatic drugs ("broad-spectrum") for this purpose should be vigorously condemned.

The indications for abortion in pregnant cardiac patients are annually decreasing. The appearance of intractable congestive heart failure in the first trimester of pregnancy is still considered an indication for abortion; however, this must not be interpreted categorically. If the failure is to be judged "intractable," for example, all possible therapeutic recourses, including cardiac surgery in appropriate cases, must have been exhausted. There is no generally accepted indication for abortion after the fourth month of pregnancy, since abortion then is at least as much a strain on the heart as would be completion of the pregnancy.

Specific types of heart disease have not been discussed separately in this presentation for the sake of brevity. With an understanding of basic cardiovascular physiology in pregnancy, and of the general measures of therapy reviewed, problems will only rarely be encountered which are unique to one type of heart disease. This is not to say that specific diagnosis is not necessary, however, for on the contrary, that is the only way to optimal understanding of the pathophysiology in a given patient.

### Summary

Most cardiac patients who can become pregnant will tolerate pregnancy to full term and normal vaginal delivery. Particular stress on the heart during pregnancy occurs in the last trimester, at delivery, and for 48 hours thereafter. Treatment of heart disease in pregnancy is based primarily on abundant rest and on careful observation by the patient's physician. The physician must particularly watch for congestive heart failure and bacterial endocarditis, the two commonest causes of death in these patients. Indications for abortion or cesarean section are now rare.

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## Three Fatal Anaphylactic Reactions Caused by Penicillin

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Three cases of fatal anaphylactic reaction due to the parenteral administration of penicillin were seen by us within a 10 month span.

In case 1, a 30 year old white woman was examined in the emergency department of a busy hospital; a diagnosis of pelvic inflammatory disease was made, and she was given 2,400,000 units of procaine penicillin G into the gluteal muscle. Although there was a previous record of penicillin sensitivity, this was not known at the time of examination. Within a matter of minutes, the patient became pale, faint, and lost consciousness. Neither pulse nor blood pressure could be obtained. Cardiac massage was performed. The patient was pronounced dead a little over an hour from the time she was first given the penicillin injection. Most of this hour was used in efforts to revive her.

An autopsy showed only minimal pulmonary emphysema consistent with anaphylaxis and slight cerebral edema. The uterus was in a menstrual state. No evidence of active pelvic infection was

found. A careful examination of the injection site showed that there was no intravascular penetration.

In case 2, a 65 year old white housewife, because of a cold that had lingered on for about 10 days, was given 450,000 units of procaine penicillin G into the gluteal muscle. Within two or three minutes, she started foaming at the mouth, became faint, pale, and died. The administration of intracardiac adrenalin failed to revive her. There had been no known allergy to penicillin. She had, however, received her last parenteral dose of penicillin "several years ago." An autopsy was not performed, but examination of the injection site revealed no evidence of entry into a blood vessel.

In case 3, a 21 year old Negro woman, eight weeks pregnant, was seen in a hospital emergency room with complaints of pains in the lower right quadrant of the abdomen, slight vaginal bleeding, headache, and vertigo. An intern first examined her and noted mild pain on palpation in the right lower quadrant, but no rigidity or rebound tenderness. Urinalysis and a complete blood cell count

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gave negative results, the white blood cell count being 8,400. After consultation with the resident, the intern ordered 600,000 units of procaine penicillin G. According to statements, the patient was asked both by the nurse and the intern whether she had ever had any difficulty taking the antibiotic, and she responded in the negative. She was then given the penicillin into the right gluteal muscle. Approximately five minutes later, she was given 75 mg. of Demerol into an arm. After another five minute interval, the patient began complaining of an itching and burning of the mouth and nose. She stated she felt as though her lips were swelling. Then, in rapid sequence, she complained of a burning sensation in her hands and feet, became incontinent both of urine and feces, vomited, perspired freely, became short of breath and cyanotic. Despite administration of Benadryl (30 mg. intramuscular), adrenalin (intramuscular and then intracardiac), Chlor-Trimenton, and artificial respiration, the patient was pronounced dead approximately 25 minutes after the penicillin injection. From the facts, it can be deduced that the whole fatal reaction took no longer than 15 or 20 minutes.

At autopsy, the salient points were congestion of the meninges, prominent edema of the aryepiglottic folds rendering them almost transparent from the glistening edema fluid beneath the mucosa, and recovery of a white milky fluid, some in the gluteal muscle, but predominantly in the subcutaneous fat overlying the muscle. The fallopian tubes were slightly dilated; the walls were thickened and edematous. The vessels were injected, but there was no evidence of an exudate.

### Comment

Despite numerous previous warnings against the injudicious use of penicillin, deaths continue to occur under circumstances in which a more prudent calculation of the risks involved should have been considered. These deaths, unfortunately, appear to be on the increase. They have been well documented in the medical literature. The true incidence, however, is unknown since the

fear of medicolegal consequences prevents all cases from being reported as such. Nevertheless, the fact that these deaths are occurring in greater frequency cannot be denied. Rosenthal<sup>1</sup> in 1954 reported a series of eight cases. In 1958, he added 18 more cases to his original eight.<sup>2</sup> In December 1957, the Food and Drug Administration reported 72 such deaths. Two months later, in February 1958, Lilly's Physician's Bulletin came out with this eye-opening statement: "It has been estimated that more than one thousand fatalities have occurred following the use of parenteral penicillin."

This increase is due to the facts that penicillin is the most allergenic of all antibiotics, that an increasing portion of the population is becoming sensitized because of repeated exposure to penicillin, and that because of its cheapness, penicillin is the most extensively used antibiotic in America, there being produced at present over 350 tons per year.<sup>3</sup>

All the foregoing demonstrates a need for greater caution and greater calculations on the part of the physician before administering penicillin either parenterally or in any of its other forms. He should observe the dictum that the risk of therapy should be less than the risk of the disease. As has been amply discussed time and again in the literature, penicillin should not be administered in cases where it cannot possibly do good, such as for the common cold. A history concerning any special manifestations of allergy must be taken and, today, busy as the physician might be, it is strongly advocated that some form of intradermal or conjunctival testing be done.<sup>4-6</sup>

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# Clinical and Laboratory Observations With a New Muscle Relaxant (Trancopal) In Athetosis

## *A Preliminary Report*

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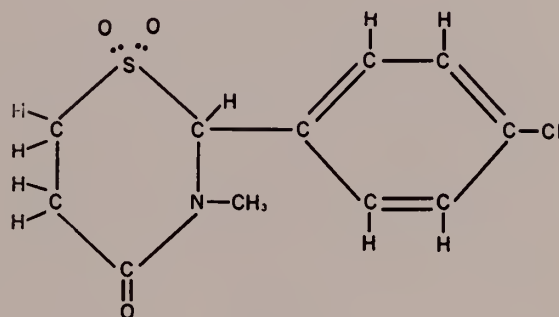
In recent years a variety of muscle relaxants have become available for clinical use, but the need for an agent of the type having a centrally depressant action of broad scope for the relief of muscle spasticity still exists.<sup>1,2</sup> It must be agreed, however, that some degree of relief may be expected with these new compounds, more particularly in those conditions characterized by muscle spasm of spinal origin. On the other hand, supraspinal spasticity presents a more formidable problem, and to date little in the way of highly efficient chemotherapy for the group of patients with this disorder has been forthcoming.

Because of the interest my associates and I have had in patients with upper motor neuron spasticity and previous experience with relaxants offering some promise for this condition, still another of these new compounds, namely, chlormezanone (Trancopal\*), came to our attention. Initially, this drug was shown in animals<sup>3,4</sup> to exert activity in the subcortical and spinal levels by an inhibitory or depressant effect upon the polysynaptic nerve pathways, and later this selective action was also demonstrated by clinical studies in various spastic disorders of the spinal type.<sup>5</sup> Impressed with these reports and eager to obtain a more effective drug for our patients, we undertook a study involving a small group of patients with spasticity primarily of the athetoid type which was secondary to kernicterus.

### **Chemistry and Pharmacology of Trancopal**

Chlormezanone is 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide and has a structural formula as shown.

This preparation is unrelated chemically to other muscle relaxants and may be said to belong to the methazanone group of compounds. It is



poorly soluble in water or alcohol and is available only in tablet form for oral use.

Extensive studies in a number of species of laboratory animals, including the primate (rhesus monkey) have revealed the drug to possess potent skeletal muscle relaxant properties. The site of action is evidenced by (1) an antagonistic effect to strychnine and Metrazol, and (2) no direct effect upon skeletal muscle, myoneural junction or peripheral nerve.<sup>3,4</sup>

Of particular interest to us was the fact that the drug may act at a cortical level, since in other animals studied the drug demonstrated some degree of tranquilizing activity and also potentiated hexobarbital sleeping time. These attributes were considered to be mild in nature and rather similar to those shown by meprobamate or zoxazolamine.

Animal studies designed to determine circulatory or autonomic effects of the drug with non-toxic doses failed to disclose any important activity upon these organ systems. Acute toxicity studies<sup>6</sup> with Trancopal in mice revealed the drug to be somewhat less toxic than meprobamate, zoxazolamine or methocarbamol, the LD<sub>50</sub> of the former being 1380±mg./kg. while that of the latter three drugs ranged from 1,000 to 1,100±mg./kg. Symptoms of toxic doses in animals (mice, dog, monkey) included ataxia or sedation,

\*Trancopal®, brand of Chlormezanone, Winthrop Laboratories, New York.

but it is of interest that no gastrointestinal disturbances were observed. Finally, chronic toxicity studies in animals have demonstrated no untoward effects upon any vital organ including the liver, kidneys and bone marrow.

### Clinical Material

Although the number of patients included in the present report is not large, the chronicity and severity of the conditions treated were such that we considered them to represent the type which would offer the most severe test of a new drug. Further, these patients had been under observation for sufficient periods of time to permit a fair appraisal of any change in their spastic state. In recording results only objective findings were considered, that is, ability to walk, change in purposeless movement, ability to eat or care for themselves, ease of handling, and alteration of behavior pattern.

Trancopal was administered to each patient three times daily in doses ranging from 25 to 100 mg.

### Results

All of the patients showed some degree of relief of spasticity. With but one exception a 50 to 75 per cent improvement was observed in the group. The beneficial response was particularly noted in regard to their ability to cooperate with the physical therapist to undertake new tasks, or to carry out such normal activities as swallowing or walking. Table 1 shows the percentage of improvement observed in the 11 cases studied.

One patient, for example, had been unable, prior to Trancopal treatment, to swallow without considerable difficulty, and two or three times a month would aspirate food. Trancopal improved his ability to swallow with less frequent choking

and without aspirating. In addition, the patient became much more relaxed and as a result easier to work with.

Others demonstrated similar responses in that their purposeless movements were considerably reduced and they showed a quieter, less disturbed behavior. In general, the drug produced a two-fold response in these patients, namely, a muscle-relaxing and a mental-quieting or tranquilizing effect. Both actions contributed to the good results in the patients as well as to the favorable comments from those who were responsible for the daily care, comfort and training of these patients.

It is especially gratifying to us that we were able to obtain such a high degree of satisfactory response without encountering any untoward reactions. Even in a group this small one might have expected some evidence of intolerance; however, none was reported. This result is in keeping with the excellent tolerance reported by Lichtman,<sup>5</sup> who noted minor side effects in only 2 per cent of over 600 cases.

### Laboratory Studies

During the treatment period with Trancopal it was deemed advisable to carry out limited laboratory studies which would further substantiate our observation of clinical tolerance. We therefore performed a cephalin-cholesterol flocculation test, red and white blood cell counts, and a urinalysis on each patient. A sedimentation rate was determined on several of the group. The results of these tests are given in table 2.

It will be noted that no significant laboratory finding was demonstrated in any patient which we could not account for by the clinical condition of the patient, such as dehydration or poor

Table 1.—Summary of Clinical Results With Trancopal

Case Number	Diagnosis	Age (yrs.)	Weight (lbs.)	Dosage Schedule (mg. t.i.d.)	Duration Therapy (days)	Approximate Per Cent Improvement	Side Effects
1	Athetosis	19	65	100	28	65	none
2	Athetosis	9	38	50	28	75	none
3	Athetosis	19	56	100	28	65	none
4	Athetosis	17	119	100	28	50	none
5	Athetosis	6	18	25	28	15	none
6	Spastic (birth injury)	16	74	100	14	75	none
7	Athetosis	9	34	100	28	75	none
8	Spastic (birth injury)	22		50	33	65	none
9	Spastic (birth injury)	4	24	50	42	50	none
10	Athetosis	20	65	50	42	50	none
11	Athetosis	17	108	100	28	75	none

Table 2.—Laboratory Studies in Eleven Spastic Patients  
Treated With Trancopal

Case Number	Cephalin-Cholesterol Flocculation Test		Sedimentation Rate mm./hr.	Red Blood Cells million/cu.mm.	Hemoglobin (Gm.)	White Blood Cells per cu.mm.	Urinalysis		
	24 hr.	48 hr.					Sp. Gr.	RBC	Alb.
1	+1	+1	17	3.9	13.4	8,400	1.020	neg.	neg.
2	neg.	neg.	6	3.2	12.5	13,500	QNS	neg.	neg.
3	neg.	neg.	6	4.1	14.0	7,800	1.018	neg.	neg.
4	neg.	neg.		4.1	15.6	8,500	QNS	neg.	trace
5	neg.	neg.		6.2	19.5	14,000	QNS	neg.	trace
6	neg.	+1		3.6	14.0	14,700	1.015	rare	neg.
7	neg.	neg.	21	4.5	13.4	8,800	1.025	neg.	neg.
8	neg.	neg.			13.8	12,900		neg.	neg.
9	neg.	+2		5.4	14.7	12,000	1.021	neg.	neg.
10	neg.	+1		4.9	16.4	17,000	QNS	occ.	neg.
11	neg.	neg.	7	5.45	19.7	6,400	1.022	neg.	neg.

appetite. In other words, there were no abnormal reactions to laboratory tests attributable to the medication.

Records of two typical cases in this study are as follows:

Report of Cases

Case 1.—A youth, aged 17 years and weighing 108 pounds, had an athetoid spastic condition secondary to kernicterus with an associated high degree of mental impairment indicated in part by an extremely limited vocabulary. Although he demonstrated the characteristic slow, continuous, purposeless movements of athetosis, the spasticity of the lower extremities was such that he could walk only with assistance. Deep reflexes were hyperactive.

The patient was given 100 mg. of Trancopal three times daily. After treatment for approximately one month, the athetoid movements were reduced by about 75 per cent. He was much more responsive to physical therapy and had learned to walk with but slight assistance. He had shown a 50 per cent improvement on previous schedules of zoxazolamine and meprobamate. There were no untoward reactions to Trancopal. Treatment was continued.

Case 2.—A girl, aged four years, suffered from a spastic state, the result of a birth injury. The anterior and posterior muscles of the trunk demonstrated pronounced spasticity with a forward curvature of the spine. There was some atrophy of muscles. Muscles of the extremities were extremely spastic with decreased deep and absent superficial reflexes. She was unable to walk. After 42 days of treatment with Trancopal in a dose of 50 mg. three times daily, the spasticity improved approximately 50 per cent. An improvement was also observed in behavior, in that the patient was less disturbed and less destructive to herself. The medication was continued with no evidence of untoward effects at any time.

Discussion

Clinical control of the abnormal movements of the athetoid patient has always presented a most difficult problem because of the location and varied distribution of the lesion in different patients. In addition, a chemotherapeutic agent which acts in a specific and fully effective manner on extrapyramidal motor syndromes, of which athetosis is but one all too frequent example, has been lacking.

The fact that a number of drugs suitable for

trial in patients with this condition have become available in recent years lends hope where previously there was little or none. Drugs such as meprobamate, zoxazolamine or methocarbamol have offered some degree of relief to these patients in some instances; however, the clinical response in conditions of supraspinal origin leaves much to be desired. The drugs mentioned have also shown a tendency to produce side effects which offset to some degree their value in the athetoid patient. Stimulation of the nervous system evidenced by nervousness or anxiety, for example, has been noted with methocarbamol. Meprobamate, on the other hand, has a tendency to produce drowsiness, while zoxazolamine has also given evidence in a small group of patients of producing undesirable effects on the central nervous system.<sup>7</sup> Although adjustment in dosage may frequently overcome such symptoms, we have experienced a great freedom from concern about this problem while using Trancopal at doses which were found to be more effective than meprobamate or zoxazolamine in the same patients. This is in line with the report of Lichtman,<sup>5</sup> which shows a comparatively lower incidence of side effects in his series of over 600 patients treated with Trancopal than had been reported in the literature<sup>8-11</sup> concerning the other three muscle relaxants.

The fact that in our cases we obtained a favorable degree of relief from muscle spasm as well as improvement in behavior suggests that similarly consistent results may be expected in a larger series.

Although the exact mechanism of this and similar drugs is not well understood, it would appear from this study that Trancopal, aside from any pyramidal effect, may have a significant degree of action in the region of the extrapyramidal



system, since the latter may be involved in athetosis.<sup>1,2</sup> This, at least in part, may account for the responses we have observed. Later studies may clarify this point.

### Summary

A series of cases is reported in which 11 patients, aged 4 to 22 years, with paralysis of the extrapyramidal supraspinal type (athetosis) were treated with a new muscle relaxant, Trancopal.

Satisfactory improvement in spasticity was observed in all; in only one patient was improvement considered to be less than 50 per cent.

Tolerance to the drug was excellent. No side effects were observed, nor were there any abnormalities noted on laboratory tests which could be attributed to the drug.

A dose of 100 mg. three times daily appears suitable for those over 12 years of age while younger patients have done well on a dose of 25 to 50 mg. given three times daily.

The results obtained in this investigation suggest that Trancopal offers a more effective form of drug therapy in this type of case than we have obtained with other compounds and indicate further that this preparation deserves continued clinical use and study in the athetoid patient as well as in related neurologic states.

**ADDENDUM:** Since the completion of this report, clinical studies were done involving 96 spastic patients (50 athetoid type) varying in age from seven to 37 years and 26 congenital epileptics (aged nine to 29 years). Trancopal Caplets were given on a schedule of 150 to 400 mg. three times daily for periods of nine to 18

months. The condition had existed since birth in the majority of these patients. Results insofar as relaxation was concerned were considered good in all spastic patients. Of the 26 congenital epileptics, 19 had combined grand and petit mal, six grand mal alone and one only petit mal. Of the 19 with the combined type receiving Trancopal, 18 had a reduction in the grand mal seizures and 14 in the petit mal. Seven patient (six with grand mal and one with petit mal) also had a reduction in the seizures on Trancopal therapy. Petit mal seizures in five patients in the combined group remained static in three and increased in two, even though the grand mal was decreased. No side effects were observed in any of the 122 patients during therapy with Trancopal.

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# Vascular Pseudohemophilia — A Case Report

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AND

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TAMPA

Defects in the clotting mechanism can be ascribed to three major causes: (1) capillary dysfunction, (2) qualitative or quantitative platelet inadequacies and (3) abnormalities and/or deficiencies in noncellular blood coagulation factors.

The case reported here is an example of the disease entity referred to as vascular pseudohemophilia. This condition belongs in the first category outlined and is characterized by a distinct tendency for unprovoked hemorrhage or protracted hemorrhage following relatively minor trauma. From a laboratory standpoint, the bleeding time constitutes the only abnormal finding, even when the most elaborate tests available are included in a thorough study of the coagulation mechanism. Although von Willebrand<sup>1</sup> first described the symptom complex of vascular pseudohemophilia in 1926, recent advances in testing platelet function have shown that in the family originally described by him, a deficiency of the platelet thromboplastin factor existed. This can be proved by the prothrombin consumption as well as the thromboplastin-generation tests. It is, therefore, not permissible to use the terms "vascular pseudohemophilia" and "von Willebrand's disease" as synonyms since in vascular pseudohemophilia these tests for platelet function are normal.<sup>2</sup>

Pseudohemophilia is not rare since it is reported as being present in 5 to 10 per cent of all patients admitted to hematology clinics because of hereditary hemorrhagic disorders.

Pseudohemophilia "unmodified" is an ill-defined entity and should be discarded in classifying hemorrhagic diseases. The terminology in the past would have been less confusing had present day methods of "coagulation profile" and "capillary microscopy" been available. With most recent authors, the term is reserved for that specific defect in which a prolonged bleeding time is the only demonstrable abnormality and at the "capillary level."

One speaks of "pseudohemophilic states" and subdivides them into: (1) those with platelet abnormalities and (2) those with normal platelet function. This division is best illustrated by Stefanini and Dameshek<sup>3</sup> as follows:

(1) THROMBOCYTOASTHENIC (THROMBASTHENIC) PSEUDOHEMOPHILIA.—The prolonged bleeding time is secondary to a qualitative platelet deficiency resulting in an ineffective fibrin clot at the site of vascular injury. Associated with the primary platelet deficiency there may be other hemostatic defects such as insufficient prothrombin utilization and abnormal clot retraction.

(2) VASCULAR PSEUDOHEMOPHILIA. — The platelets are qualitatively and quantitatively normal, but according to MacFarlane<sup>4</sup> the bleeding tendency is related to the inability of the capillaries to contract in response to trauma. This disease is congenital, frequently hereditary and involves either sex.

(2) VASCULAR PSEUDOHEMOPHILIA.—THE CIATION WITH HEMOPHILIA.—In this combination of conditions the capillary defect is superimposed on other congenital abnormalities, particularly antihemophilic globulin (A. H. G.) deficiency. This defect was noted in a report by Schulman and others.<sup>5</sup> The antihemophilic globulin deficiency here differs from that seen in classical hemophilia in that both sexes are affected and hereditary transmission is probably autosomal and not sex-linked. Singer and Ramot<sup>2</sup> suggested the term "pseudohemophilia B" for this condition. Probably belonging in this category are other combinations of congenital abnormalities of the hemostatic mechanism in which the over-all manifestation is a prolonged bleeding time.

Uncomplicated vascular pseudohemophilia affects both sexes and is probably transmitted as an incomplete autosomal dominant. In patients with this disease bleeding usually begins early in life with the hemorrhages being uncommonly spontaneous, but resulting rather from even minor trauma. The hemorrhagic tendency usually becomes less severe with age. The susceptibility to hemorrhage may vary from time to time in any one patient, and the severity of the bleeding bears no constant relationship to the abnormalities in the bleeding time. Epistaxis, hematomas, uterine hemorrhage, gastrointestinal blood loss and cutaneous extravasations are fairly common, while



bleeding from the lungs or kidneys, or into the joints is more unusual. Cerebral hemorrhage is rare. The disease is more severe in females with a resulting greater mortality. It is markedly resistant to treatment as exemplified by our case here described:

### Report of Case

A 47 year old white unmarried woman was admitted to a Tampa hospital on March 15, 1958, because of melena of three weeks' duration. She was admitted as a transfer patient from a smaller outlying hospital after the blood bank there was depleted of its small store of blood and plasma (13 units). There had been no previous history of gastrointestinal bleeding.

**Past History.**—Apart from vague upper abdominal distress extending over a period of many years and complaints related to bleeding, the medical history was noncontributory. The patient stated that she had been a "bleeder" all her life with this tendency being manifested by frequent epistaxis, easy bruisability and genitourinary hemorrhage in childhood. When she was 18 years of age, roentgen therapy was administered because of menorrhagia and metrorrhagia. When she reached 40 years of age, artificial menopause was induced by the same therapeutic expedient for similar reasons. At no time were teeth extracted for fear of troublesome bleeding. No operation had been performed at any time during her life.

**Family History.**—The patient had two brothers and one sister. The sister died of internal hemorrhage following a fall from a bicycle. One brother died of uncontrollable genitourinary hemorrhage and an uncle of severe epistaxis. The one surviving brother suffers from recurrent hemorrhages from the gastrointestinal and genitourinary systems. Apart from the foregoing, the family medical history was noncontributory.

**Physical Examination.**—There were no abnormal physical findings, except for moderately carious teeth and the previously mentioned melena.

**Laboratory Findings.**—Urinalysis gave completely normal results. Examination of the blood showed the hemoglobin level to be 8.9 Gm. per hundred milliliters and the white blood cell count 6,650 per cubic millimeter with a differential count of 4 per cent unsegmented neutrophils, 66 per cent segmented neutrophils, 24 per cent lymphocytes, 3 per cent eosinophils and 3 per cent monocytes. The reticulocyte count was 8.8 per cent. The bleeding time (Ivy) was over 40 minutes in repeated determinations, the platelet count 220,000 per cubic millimeter, the one stage plasma prothrombin time 15 seconds, and the serum prothrombin time 45 seconds. The Rumpel-Leede test gave negative results. The Lee-White clotting time (3 tubes) was 10 minutes. At the end of one hour there was good clot retraction with the formation of a firm clot; the clot remained firm for a period of over 24 hours, thereby indicating the absence of significant fibrinolysis.

The plasma fibrinogen concentration was 497 mg. per hundred milliliters; a heparin protamine titration test gave normal results. The stool gave a 4 plus reaction to the guaiac test; the gastric contents were negative for blood. The total serum bilirubin was 1.1 mg. per hundred milliliters; the blood urea nitrogen was 12 mg. per hundred milliliters. Several gastrointestinal roentgen series and barium enemas gave negative results. Roentgenograms of the chest show no abnormalities (table 1).

Table 1.—Diagnostic Studies

Roentgenograms
All essentially normal
Gastrointestinal series
Small bowel studies
Barium enema

**Laboratory Studies.** All within normal limits, except Ivy bleeding time

Routine complete blood cell count and urinalysis
Serum prothrombin consumption time
Thromboplastin generation test of Biggs and Douglas
Heparin protamine titration
Bromsulphalein
Serum pepsinogen
Serum glutamic oxaloacetic transaminase
Coombs test
Plasma fibrinogen
Electrolytes
Platelet counts
Repeated Ivy bleeding time
Coagulation Lee-White
VDRL
Urine hemoglobin
Urea, creatinine, bilirubin, sugar
Electrophoretic serum protein

From the foregoing results it was concluded that we were in all probability dealing with a hemorrhagic diathesis, and in this regard the possibilities were narrowed down to thrombasthenic pseudohemophilia, a vascular pseudohemophilia, or a combination of vascular pseudohemophilia and hemophilia. The differential diagnosis was accomplished by means of the extremely sensitive thromboplastin generation test (TGT)\* of Biggs and Douglas. This test gave entirely normal results. Thrombasthenic pseudohemophilia was excluded as a possibility in this case because of the normal generation of thromboplastin when the patient's platelets were substituted for the normal control platelets at an appropriate phase in the execution of the thromboplastin generation test. Vascular pseudohemophilia associated with hemophilia was excluded both by the normal prothrombin consumption value and, even more conclusively, by the normal results obtained in the thromboplastin generation test. Thus all the criteria for the diagnosis of vascular pseudohemophilia were satisfied.

**Therapy and Hospital Course.**—Throughout her hospital stay until shortly before her demise, the patient exhibited relentless intestinal hemorrhage of moderate severity requiring the administration of 1 to 2 units of fresh blood daily. A total of 181 units of blood, plasma, washed cells, fibrinogen and platelet concentrates was administered during the hospitalization period of three months (table 2).

Table 2.—Breakdown of Transfusions  
from March 15 to June 23, 1958

Platelet concentrate	4
Washed cells	12
Plasma	26
Fibrinogen	6
Whole blood (fresh)	133
Total	181

All therapeutic efforts directed towards bringing the bleeding under control met with no success. The therapeutic measures tried are listed in table 3 and represent a formidable array including oral topical thrombin, parenteral Stypturon\*\* and intravenous Serotonin † as well as the steroids.

Table 3.—Drugs

Topical thrombin
Pro-Banthine
Adrenosem
Vitamin K <sub>1</sub>
Vitamin C
Gelfoam
Aristocort
Solu-Cortef
Premarin
Zinc cortitrophin

\*Courtesy of Drs. Patterson and Catanzaro—Laboratory of Clinical Pathology.

\*\*Stypturon supplied by Abbott Laboratories.

†Serotonin supplied by the Upjohn Company.



CVP with and without Vitamin K; flavonoids  
Calcium gluconate  
Barium sulfate  
Knox gelatine  
Percorten  
Desoxycorticosterone  
DEPO-Testosterone  
Hykinone  
Hesperidin  
Serotonin—8 days  
Protamine  
Stypturon  
Dextran  
Cortisone

The rationale for the use of Serotonin was based on MacFarlane's findings relative to the capillary functional impairment in this disease coupled with the later discovery that platelets release 5-hydroxy-tryptamine (Serotonin) which causes capillary spasm in response to injury. Serotonin was administered intravenously in a daily dose of 10 to 40 mg. without any measurable effect on the clinical status of the patient or on the bleeding time.

Stypturon (a low molecular weight derivative of polygalacturonic acid) was tried because of the reported effectiveness of this drug in inducing hemostasis at a bleeding site. This, according to German pharmacologic data, is attributed to this agent's capacity of producing increased lability of platelets and to their increased tendency to agglutinate where there is a local increase of thrombokinas due to injury. No beneficial effect was observed after parenteral administration of this substance, and its use was, therefore, abandoned.

Finally, because of the report of Stefanini and Martino<sup>6</sup> concerning the effectiveness of ACTH and the corticosteroids in combating the hemorrhagic tendencies and in reducing the bleeding time in these patients as well as because the situation was desperate, we decided to resort again to the corticosteroids despite the fact that these had previously been used unsuccessfully in this case. The material was, however, given in much larger doses the second time. Cortisone was administered orally initially in a dose of 100 mg. every three hours, and the dose was gradually diminished over the succeeding several days. Five days after this therapy had been instituted, melena ceased completely, and the hemoglobin level remained stable. The bleeding time, however, persistently exceeded 30 minutes. Further evaluation of the effect of cortisone became impossible since two days later the patient became unconscious and manifested a slow pulse and clonus of all extremities. She died shortly thereafter.

At autopsy, numerous hemorrhages were found throughout the brain. The stomach and intestines were entirely normal, and the intestinal contents showed no gross evidence of recent or old bleeding.

### Summary

A case of vascular pseudohemophilia in a 47 year old white woman is presented. The diagnosis was established on the basis of family and personal history, the laboratory data, especially the results of the bleeding time, the normal prothrombin consumption and, above all, the results of the thromboplastin generation test. The clinical course in the terminal phase with the relentless exasperatingly prolonged gastrointestinal hemorrhage is typical of this disease entity, though the extensive intracerebral hemorrhages accounting for the patient's demise are a rare cause of death in this category of hemorrhagic diatheses. The various therapeutic measures tried are described. The dramatic cessation of intestinal bleeding a few days prior to death and following the administration of a massive second course of corticosteroids is of particular interest. Hemostasis was not unequivocally related to cortisone therapy, and the bleeding time remained unaffected by the drug. Though no final conclusion can be reached except that possibly this form of therapy in high dosage should be tried first and early in any future patient presenting a similar problem.

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# The Differential Diagnosis of the Child Without Speech

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BATON ROUGE, LA.

In this presentation, I want to discuss the child without speech, with particular reference to making a differential diagnosis of his inarticulate status. Otolaryngologists are seeing such children without speech more and more often today, for several reasons. One of them is that more and more children are surviving the perils of being born because obstetricians are handling toxic and hemorrhagic conditions in the mother with more skill. The erythroblastic child now has a good chance of life, and pediatricians, with the aid of antibiotic and chemotherapeutic agents, are saving children with meningitis and encephalitis. These conditions all are apt to leave residua, one of which is that the child does not acquire speech.

There are thus more of these inarticulate children today than there ever were before, and therefore the proportion of referred cases is much higher. General practitioners and pediatricians, who usually see these children first, have become aware of the need for a differential diagnosis of the inarticulate state and are also aware that the differentiation must be made early if full advantage is to be taken of the potentialities of the child. I do not believe there are many physicians today who would follow the old custom of telling parents that the child is too normal otherwise to have anything wrong with him, or that he will probably outgrow his unawareness of sound, or that, if his hearing is really impaired, auditory testing will be impossible until he is five or six years old.

This sort of bad advice is not often given today. There is, however, another danger against which we must be on our guard. Like many otolaryngologists, I am concerned over the many presentations at medical meetings, the many articles in the medical as well as the lay literature, and the many radio and television programs which give misleading advice about technics of testing these inarticulate children. They emphasize the use of psychogalvanic skin resistant audiometry (the PGSR test), electroencephalography, and

pure tone audiometry by various modifications of the peepshow technic, and one might easily derive the impression that only by these methods can a correct diagnosis be made.

The impression is most unfortunate and is far from the truth. These tests have several undesirable features. The equipment is expensive. It can be operated only after special training. Nearly all of the tests require two people, or more, to carry them out. Finally, the tests are unsatisfactory because they are based on the response to pure tone, to which a young child does not respond readily. He responds much more readily to mixed tones.

I do not want to give the impression that I am opposed to these tests per se. I am not. They are excellent provided that they are used on the proper indications and that they are regarded merely as adjuncts to more basic procedures.

Let us examine these tests more closely. The PGSR test is based on conditioning the patient to pure tone and electric shock. It is entirely unsatisfactory in children under three years of age with peripheral hearing loss, and even over this age, the response is not always reliable. It has no place in the diagnostic study of the child without speech, for aphasic and emotionally disturbed children are apt to have high thresholds to the discomfort of the shock and might therefore show a considerable impairment of auditory acuity when actually their threshold might be at a practical level or better.

Electroencephalography requires the child to respond to pure tones, and here the difficulty is that the test has not been carried out on enough normal children to establish normal thresholds. In many instances children who were reported to have marked hearing losses on electroencephalographic testing, whether it was carried out during the waking hours or during sleep, have been found to have hearing acuity adequate for acquiring speech.

Finally, the various modifications of the peepshow technic are also based on response to pure tones. The test is much too demanding for emo-

tionally disturbed and mentally deficient children, or with aphasia from brain injuries. They are distracted by the use of visual as well as auditory stimuli, and they lack the ability to cooperate for such a test.

At the Tulane Speech and Hearing Center we use these tests almost daily, but they are not the answer to the problem of differential diagnosis in the child without speech. For this, we must go back to the simpler methods, the taking of a good complete history; careful observation of the child; clinical evaluation; and finally, testing, but testing with more basic instruments, such as noise-makers. Formal pure tone tests should be employed only after the diagnosis has been made, and then only to confirm it if that seems, for any reason, necessary or desirable.

#### Questionnaire

In my own office, we secure the history before we see the child. When the first appointment is made, we tell the mother that we are sending her a questionnaire which we would like her to fill out completely and return to us for study before we see the child. This system means that both parents can fill in the questionnaire without pressure, and, if they do not know all the answers, they can talk to the obstetrician or the pediatrician and secure the necessary information. When the questionnaire is returned, we have the opportunity to go over it, and we then have some idea of the situation before the child is examined.

The questionnaire which we have worked up is detailed. It includes the following items:

1. The prenatal history, including all details of the mother's status during pregnancy.
2. The birth history, including the length of the pregnancy, the duration of labor, and the type of delivery.
3. The child's condition at birth. This should include such items as his weight at birth; the presence of scars or bruises; the presence of cyanosis or jaundice; and any indication of brain damage.
4. Conditions immediately following birth, including the restoration of the birth weight, seizures, swallowing, sucking, and any feeding difficulties.
5. The history of childhood disease, diseases of the nervous system, diseases affecting the middle ear, and details of whatever illnesses have occurred.
6. Inoculations, including the type, the age

at which the injection was given, and any after-effects.

7. The history of any surgery, with details.

8. The familial history, including hearing loss, alcoholism, epilepsy, and mental illness.

9. The genetic development, including such matters as at what age the child first showed response to the mother; at what age he sat alone, walked alone, drank from a glass, ate with a spoon and fork, pulled off his socks, dressed himself, asked to go to the toilet, and attended to his own toilet needs.

10. His emotional development. Does he show concern when he is separated from his parents? Is he responsive to people? Is he sensitive to vibrations and to being touched? Does he shed tears when he cries? Is he easily distracted? Is he hyperactive? Is his behavior consistent from day to day? Is he withdrawn? Is he easily managed in the home? Is he playful with children, adults, or pets? How does he eat and sleep?

Finally, the questionnaire covers the details of the child's auditory and language behavior, including how he makes his wants known, and his educational history.

#### Examination

With a questionnaire of this sort, duly filled in by the parents and duly studied by the otolaryngologist, the stage is set for the examination of the child. We are particular about the circumstances of the examination, trying to make them seem as natural and informal as possible. A secretary, not a nurse, brings the child and mother into the office. The physician's white coat is omitted. The appointment is preferably the first of the day, so that the child and his mother, like ourselves, may be fresh and rested and that the proper rapport may be established. A great many parents of inarticulate children are supersensitive, and care must be taken that they do not get the idea that the physician is not intensely interested. Once they have such an impression, they become antagonistic.

The child must also be handled carefully. He may have recollections of visits to other offices and of associated unpleasantness. If, therefore, he is old enough to walk, he is temporarily ignored and allowed to move about the room as he pleases. Sometimes his attention is caught by something out of the window. If it is not, he is given a toy to play with; a bright scarlet tennis ball or some other indestructible toy is best for the purpose. If



the toy is not indestructible, the mother is apt to be distracted by trying to keep the child from destroying it. We need her full attention for the business at hand.

The interview is a sort of three ring circus. The physician goes over the questionnaire with the mother, seeking further details in special replies. At the same time, he observes the child unobtrusively, and evaluates his appearance and activity. Still at the same time, he presents sounds to him and notes his response.

There are a large number of observations to be made on the child, including the type of his speech; the character of his vocalization; how he uses gestures; how he laughs, smiles and cries; if he is sensitive to movement and other visual stimuli; and how he responds to sound.

All of these observations are necessary, for hearing covers fields of activity in all directions while vision is focused on activities in the foreground. A child with impaired hearing, for instance, changes his position to help his vision and therefore seems more bright and alert. A child who is aphasic because of brain damage cannot compensate for the loss of one sense by the use of another. An emotionally disturbed child, not being interested in the outer world, does not rely on his vision. In the mentally deficient child, all the sensory responses are about equal.

Another point to be observed is the facial expression. A child with impaired hearing is unusually responsive to facial expression. An aphasic child is incapable of sustained attention. The emotionally disturbed child ignores face to face contact. The mentally deficient child will respond to expressions of warmth and acceptance but not to subtle expressions.

It is necessary to study the response to tactile sensation and also to study the motor behavior. A child with impaired hearing uses visual and tactile sense as a means of compensating for his hearing loss. The aphasic child is limited in his ability to select stimuli appropriate to his needs. An emotionally disturbed child behaves according to his acceptance or rejection of special stimuli. A mentally deficient child, generally speaking, uses the visual and tactile senses in proportion to his mental capacity.

It is also necessary to know something about the child's emotional expression and development, in which hearing plays a major role. Echolalia (parrot or echo speech) must be looked for; this is automatic and immediate imitation of the

speech of others, without comprehension of what has been said. It occurs in conditions other than peripheral hearing loss, though it does not occur in schizophrenics. Finally, perseveration, distractibility and disinhibition must be investigated. These occur in all children, but are particularly marked in aphasics.

We have found the most satisfactory method of testing young children is by the use of noise-makers in a free field. The most satisfactory types are obtained from music supply houses and make sounds from 200 to 5,000 to 8,000 frequencies. An attempt is made to check the frequency or frequency range with an octave band analyzer and a sound level meter; all we want to know is that by applying a certain stimulus to a certain noise-maker, so many decibels of sound will be produced at such and such a distance.

Most of the response of these small children is in the form of so-called cessation of activity technics. As the term implies, the child stops whatever he is doing because a certain noise is impressed upon his consciousness. Noise-makers cover such a wide range that it is impossible to assign a single frequency to any given instrument, and the cessation of activity response is therefore simply a crude indication of the response or lack of response to sound. It does not indicate the exact hearing loss for a specific frequency or group of frequencies. Moreover, a child's response to one noise-maker rather than to another may have nothing to do with the physical characteristics of the sound. The response may be based on how greatly one sound or another attracts his interest or arouses his curiosity or startles him or amuses him, and this response may be based, in turn, on his background and past experiences quite as much as on his hearing ability.

In the use of noise-makers for diagnostic purposes, therefore, history, observation, and response to these instruments must all be taken into account before conclusions are drawn. It is sometimes necessary to see the child a number of times before the differential diagnosis can be made. It might be of interest that in 20 per cent of the inarticulate children observed at the Tulane Speech and Hearing Center, as well as in our private practice, the lack of speech is on the basis of peripheral hearing loss.

### Summary

The differential diagnosis in a young child without speech is often difficult and time-con-

suming, but it is best arrived at by a good history supplemented by careful observation and clinical evaluation. Testing comes last, and when it is done, it should be done with mixed and not pure

tones, to which the young child does not respond readily.

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## ABSTRACTS

**Group A Beta Hemolytic Streptococci and Rheumatic Fever in Miami, Florida. I. Bacteriologic Observations from October 1954 through May 1955.** By Milton S. Saslaw, M.D., F.C.C.P. and Murray M. Streitfeld, Ph.D. *Dis. Chest* 35: 175-193 (Feb.) 1959.

These authors report an intensive baseline investigation of group A beta hemolytic streptococci isolated from the throats of children six to nine years of age, carried out in three Miami public schools by means of monthly throat culturing of 333 children during the school year, October 1954 to May 1955. Concurrently, a county-wide survey was made in 48 additional elementary schools throughout Greater Miami (Dade County); the 1,200 children, ages six to nine, in this portion of the study were cultured one time only, at the rate of 150 children per month. Both baseline and county-wide studies confirmed their previous observations (1953, 1953-1954) that group A streptococci could be recovered frequently from the throats of children in this most southernly large city, the baseline study revealed that 44.7 per cent of an average of 304.6 children harbored group A organisms at least once during the eight month school year. Monthly average isolation rates of group A streptococci were 14.16 per cent in the baseline study and 14.25 per cent in the county-wide survey. The similarity in these two rates indicates, in the opinion of the authors, that the baseline study is representative of the county-wide prevalence of group A organisms in the age group, six to nine years.

There was a small, but definite, decrease in the streptococci recovery rate with advancing age, in six to nine year old children, in both investigations. Group A streptococci were isolated from the throats of six to seven year old boys more frequently than girls; the proportion of boys to girls, ages seven to eight, harboring these organisms, was about equal; in eight to nine year old children, girls' throats were positive for strepto-

cocci much oftener than boys'. This apparent relationship in the 1954-1955 school year of sex and age to streptococcal recovery rates held for both the baseline and the county-wide surveys.

**Medical Research in a Community Hospital.** By Alvan G. Foraker, M.D. *Am. J. Clin. Path.* 31:248-259 (March) 1959.

The author relates his experiences in the development of a research program in a general community hospital without university affiliation and located in a city without a medical school. He describes the first two years of a research program in a new and fairly typical community general hospital, which demonstrates what can be done today in a generally favorable environment and also illustrates the role that the community hospital pathologist can play in such a program. It is his belief that a program of this kind has value, that it can produce worthwhile, if modest, investigations, and that it can be of assistance in patient care and medical education. He cites certain general principles that should be widely applicable: (1) some previous experience and interest in research by the pathologist and other key personnel; (2) a favorable attitude on the part of the governing board, administration, and medical staff; (3) a program designed to aid and not to interfere with care of patients; (4) careful attention to selection of projects and of possible sources of support; and (5) sound public relations. With these, he concludes, a community hospital can have a research program that will better enable it to fulfil its total responsibilities. The pathologist is the natural keystone of this endeavor. Without him, it is bound to fail. With his active participation, it should succeed.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in *The Journal*. If you have no extra reprints, please lend us your copy of the journal containing the article.



## "The Spirit of Saint Louis"

There is no doubt about what the name which serves as a title has meant to the development of aviation. I am sure that everyone interested in any phase of aviation is fully aware of just what this particular "Spirit" under the guidance of Colonel Charles A. Lindbergh has meant to the development of his particular special interest and, in turn, its effect upon the history of the world.

On this page in October, I told you that a few of us were on our way to St. Louis to a special conference and that I would report to you later. This conference was called by the American Medical Association. It was a special meeting of the presidents of all 50 state medical associations and other selected leaders and representatives. Those from 49 states were present. Only the representatives of Alaska found it impossible to make the long trip on what was a very short notice. I was accompanied to this conference by Dr. H. Phillip Hampton of Tampa, our key legislative man; Dr. S. Carnes Harvard of Brooksville, a member of the Board of Governors; our Executive Director, Mr. W. Harold Parham; and Mr. Alvin D. James, the head of the legislative department of our Jacksonville office. We were most pleased that Mrs. Perry Melvin of Miami joined us in St. Louis representing our Auxiliary.

This conference was the first of its kind in our Association's history, and it is the sincere hope of all who were there that it will make history—not just history in Medicine but history of benefit to the culture as well as the health of mankind. It is hoped it will be as important in the future development of our profession as was the original—"The Spirit of St. Louis"—in the development of aviation.

The philosophies discussed in St. Louis were, because of the short time remaining, directed at one particular piece of legislation now before the Congress—H.R. 4700 or the Forand Bill. The details on this and suggestions of how we can all help in combating this back door legislative effort at socializing Medicine are given in detail in a packet sent to the president of your county society this past month. Your officers will present this information to you, and we rely on you to disseminate these real facts to your individual public. Remember, the truth is on our side. Let us spread that truth.

It is everyone's hope, however, that the "spirit" conceived in St. Louis will continue and grow, and become an important leader in guiding the destinies of our nation. Doctors of Medicine must of necessity be among the most educated and learned in their communities. This training gives us other responsibilities than just that of being guardians of the public's health. When this country fought and won its freedom, three Doctors of Medicine signed the Declaration of Independence. But that did not finish the job. We must assume our rightful role as intelligent, educated leaders in the community in this year of 1959-1960 and all others to come.

The thought presented in St. Louis was that it is not too late for the medical profession to cure the apathy of the American citizens. This cannot be done by halfhearted methods. It will require the constant attention and effort of all of us. If we wish to have majority rule in this country, a majority must go to the polls and that majority must be informed, thinking American citizens. It is only by curing the apathy of a majority of such citizens and getting them to the polls on election day that we will ever stop the world's parasites—Socialism and Communism—that spread on the loud voices of a small minority.

The medical profession can be the determining factor in bringing such about. We must take an interest in politics before politics takes us. We must not be intimidated by the smear tactics of our adversaries. We cannot leave this job to a few; we cannot leave it for "George" to do. Each of us must become a missionary within the circle of his own acquaintances and explain to his patients and friends the general advantages of our free enterprise system. More specifically, explain to them what American Medicine under such a system has done for the health of the average American and for his life expectancy.

It is not "too late." If we all put our minds to this task in unison, we will go a long way toward making the old Christmas carol a reality.

*"PEACE ON EARTH, GOOD-WILL TO MEN"*





# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## Errors of Yesterday

FRANK G. SLAUGHTER, M.D.

Eight hundred years ago, the Jewish physician-philosopher Maimonides wrote in an oath and prayer for physicians: "Grant me strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he may obtain new light on what he thinks himself sure of today."

These words might well have been written of medicine today—or tomorrow.

The advent of the antibiotic era less than 20 years ago promised to inaugurate a true golden age of medicine. Wags spoke of the time when robots would give injections and the diagnostic genius of the clinician would be superseded by machines. The succeeding years have indeed seen great strides in the application of scientific discovery to the healing art; yet the physician of today must be constantly on the alert to "discover his errors of yesterday" and particularly to "obtain new light on what he thinks himself sure of today."

A microbe largely ignored yesterday, the *Staphylococcus aureus*, is today's greatest medical problem. Paradoxically enough, the scourge is often harder to control in large medical institutions where the greatest progress against other disease is being made, than in smaller ones where technics for preventing contamination are more effectively carried out. If medicine was complacent 15 years ago in the assurance that the "wonder drugs" had revolutionized the treatment of disease, that complacency has largely been wiped out by a common microbe which is still not fully controlled.

In the socioeconomic field, the spectacular rise in plans for prepayment health insurance repelled for a time forces seeking to regiment the physician under government control. And yet health insurance has not proved free from the cancers of greed and exploitation. In fact, the very efficiency of medical science has so pyramided costs that the whole structure of prepaid medical care is in danger of toppling under the burden of increased expense. Already the "little cloud . . . like a man's hand" of Elijah has risen in the form of

the Forand Bill; failure to stem rising costs can only make it larger and more formidable.

In still another sphere—perhaps the gravest of all—the errors of yesterday are rising to plague physicians of today. As this is being written, at least four national magazines, with circulations running into many millions, are carrying articles which examine critically and frankly the breakdown in the atmosphere of mutual trust and respect which has always characterized the patient-doctor relationship. The question of why this breakdown has been allowed to come about goes deep into the very foundations of medical education in recent decades.

The science of medicine is effectively taught in our medical schools, the art much less so, but with increasing knowledge of psychosomatic relationships, steps to improve that lack are being taken. The calling of medicine, however, the traditions of idealism and sacrifice which make up the physician's heritage, are taught hardly at all.

Medical history is neglected in favor of clinical microscopy and biological chemistry; ethics are hardly mentioned. A true American is as proud of his country's glorious past as he is of its often confused present, but a physician can hardly be expected to have pride in his calling without some knowledge of its roots and its ideals. The man in the street has always tended to place his doctor upon a pedestal. When he discovers the alarming fact that doctors of today are no longer as conscious of their heritage of sacrifice and service as were the Maimonides and Walter Reeds of the past, the dragon's teeth will have been sown and the bitter harvest of public distrust will be not far in the future. In the celebrations of Christmas, let us not forget the tomorrow of the New Year, when the errors of yesterday must be corrected.

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Editor's Note: The Journal is honored to have for the seventh consecutive year a guest editorial befitting the Christmas Season from the pen of Dr. Frank G. Slaughter, of Jacksonville, Florida's distinguished physician-author.

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## Indications for Cardiac Catheterization

It is now almost 30 years since Forssman, the German scientist, performed the first cardiac catheterization on himself. There is little doubt that this initial step, later developed by Courmand and Richards, is the single most important advance in cardiovascular research and diagnosis in this century.

Cardiac catheterization provides the means for measurement of oxygen and pressure changes in the various cardiac chambers. These data will localize intracardiac shunts and establish the pressure gradients and flow across various valves and thus the relative degree of obstruction or insufficiency of a particular valve. All chambers of the heart are now easily accessible by the conventional venous catheterization of the right atrium, right ventricle and pulmonary vascular tree and by direct needle puncture of the left atrium and ventricle. It is indeed fortunate that only a small percentage of patients with cardiovascular disease requires evaluation by these technics as they are time-consuming and occasionally hazardous. The principal clinical purpose of cardiac catheterization is for the diagnosis or exclusion of surgically

remedial lesions. It is now general practice, on clinical judgment and without prior cardiac catheterization, to correct surgically the following uncomplicated lesions: patent ductus arteriosus, coarctation of the aorta, pure symptomatic mitral stenosis, constrictive pericarditis, arteriovenous fistula, and free aortic regurgitation.

Catheterization of the right side of the heart in conjunction with indicator dye dilution curves is indicated and of value in establishing the following diagnoses: atrial septal defect with or without anomalous pulmonary venous drainage, ventricular septal defect, tetralogy of Fallot, Eisenmenger's complex (ventricular septal defect with pulmonary hypertension), pulmonary stenosis with or without an associated atrial or ventricular septal defect, and primary pulmonary hypertension.

Simultaneous catheterization of the right and left heart is indicated in assessing the severity or significance of the following: mitral regurgitation, congenital or acquired aortic stenosis, and mitral stenosis in association with clinical mitral regurgitation or when accompanied by other valvular lesions, particularly aortic stenosis.

Retrograde brachial arterial catheterization of the aorta in conjunction with indicator dye dilution curves and injection of contrast mediums is indicated when an aortic-pulmonary window or atypical patent ductus is suspected. In such cases accurate and careful clinical evaluation is essential to the selection of patients for immediate catheterization. In general, the patients with symptoms related to their specific cardiac lesions and/or cardiac enlargement or hypertrophy should be considered for evaluation by the cardiac diagnostic methods mentioned.

Aortic stenosis is the prime example of the necessity of left heart catheterization prior to surgery. Angina pectoris commonly accompanies this lesion. It may be related to severe aortic stenosis per se, and precise pressure gradients and aortic valve flow determinations help to establish the severity and significance of the stenosis. Likewise, angina pectoris may reflect severe coronary sclerosis, and the accompanying aortic stenosis may be of no hemodynamic significance. Surgical approach in the latter produces disastrous results. The degree of pulmonary hypertension and relative size of the intracardiac shunt with atrial and ventricular septal defects should

be established, and the relative urgency for surgical correction can be determined from these data. The hemodynamic significance of mitral insufficiency and aortic valve lesions accompanying mitral stenosis should be determined as far as possible since the surgical procedure of choice at the moment for predominate mitral stenosis is finger fracture of the mitral valve; however, open heart surgery with total cardiopulmonary bypass is the approach of choice when significant aortic stenosis or mitral regurgitation accompanies mitral stenosis.

In this era of rapidly advancing cardiac surgery accurate diagnosis is essential as surgical mortality and morbidity have not been reduced to the absolute minimum. It is clear, however, that as open heart surgery becomes more perfected, indications for and the absolute value of catheterization will diminish considerably. Clinical diagnosis and judgment will then dictate the vast majority of the patients to be subjected to operation.

LAMAR E. CREVASSE, M.D.  
INSTRUCTOR IN MEDICINE  
DEPARTMENT OF MEDICINE  
COLLEGE OF MEDICINE  
UNIVERSITY OF FLORIDA

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## Excellent Scientific Program Planned For Forthcoming Annual Meeting

The scientific program for the Eighty-Sixth Annual Meeting of the Florida Medical Association, to be held at the Hotels Robert Meyer and George Washington, Jacksonville, April 8-11, 1960, promises to be an excellent one.

Your Committee on Scientific Work, with the cooperation and help of the special interest groups throughout the state, has planned a symposium on "Recent Developments in Treatment of Infections" for Saturday morning, and, to date, the following men have accepted:

Florida Academy of General Practice—

E. L. Foltz, M.D., Philadelphia, Pa.

Florida Pediatric Society—Richard T.

Smith, M.D., Gainesville, Fla.

Florida Society of Dermatology—J. Graham

Smith Jr., M.D., Miami, Fla.

These men will present their thoughts on specific phases of infection and its treatment and then

take part in a panel discussion on the more general phases of this problem.

On Monday morning, a panel on "Management of Acute Trauma" has been scheduled. Letters of acceptance from the following participants have been received:

Florida Society of Plastic and Reconstructive Surgery—John M. Converse, M.D., New York, N.Y.

Florida Neurosurgical Society—Paul C. Bucy, M.D., Chicago, Ill.

Florida Orthopedic Society—Crawford J. Campbell, M.D., Albany, N. Y.

Florida Chapter, American College of Surgeons—John L. Bell, M.D., Chicago, Ill.

Each of these men will present a 20 minute talk on specific phases of this problem and will then participate in a panel discussion on the general subject.



It is hoped that the members of our Association will take advantage of this opportunity and will plan now to present any special problems for discussion before these panels by notifying the Committee on Scientific Work of specific phases of these subjects which you think should be stressed so that the Committee, in turn, may communicate these thoughts to the speakers.

The second scientific session, which will be held on Saturday afternoon, is to be devoted entirely to the presentation of papers authored by the members of the Florida Medical Association. If you have not forwarded a summary of any paper which you might wish to present, please do so at once so that it will receive full consideration in the formulation of this portion of the program.

The interest displayed by the physicians of Florida in bringing to Jacksonville their hobbies and collections for display among the scientific exhibits has, to date, been disappointing. The Committee hopes that this lack of response has been due to preoccupation with the practice of medicine and personal problems. Do forward at once any thoughts on this subject, and should you wish to prepare an exhibit, notify the Committee of your intention.

PLAN NOW TO ATTEND THE ANNUAL MEETING, APRIL 8-11, 1960, HOTELS ROBERT MEYER AND GEORGE WASHINGTON, JACKSONVILLE.

THAD MOSELEY, M.D., CHAIRMAN  
COMMITTEE ON SCIENTIFIC WORK

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### **Florida Diabetes Association Annual Meeting Held**

The Florida Diabetes Association held its seventh annual session at the Balmoral Hotel in Miami Beach on October 29 and 30. The meeting was especially well attended, and it was decided to hold the annual meeting there in October again next year. The association was highly gratified with the work of the three very active lay affiliates in the state in Manatee, Pinellas and Dade counties, and plans are in the making for the establishment of a camp for diabetic children in Florida.

Officers for 1960 are Dr. Grover C. Collins, of Palatka, President; Dr. Morris B. Seltzer, of Daytona Beach, President-Elect; and Dr. George F. Schmitt Jr., of Miami, Secretary-Treasurer. Re-elected to the Board of Governors were Dr.

Fred Mathers, of Orlando, Dr. George H. Garmany, of Tallahassee; and Dr. Schmitt. Dr. James B. Tobias, of St. Petersburg, became a new member of the Board.

The scientific program was presented in cooperation with the Florida Medical Association, the Florida State Board of Health, the University of Miami School of Medicine, and the Division of Postgraduate Education of the College of Medicine of the University of Florida. Distinguished guest speakers were Dr. Nicholas P. Christy, of New York; Dr. Jerome W. Conn, of Ann Arbor, Mich.; and Dr. Francis D. Lukens, of Philadelphia.

The closing event was a well attended public meeting sponsored by the Greater Miami Lay Diabetes Association with the Seminar lecturers speaking on new advances in the field of diabetes mellitus.

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### **1960 Annual Conference For County Medical Society Presidents and Secretaries Jacksonville, Jan. 16 and 17**

Under the auspices of the Florida Medical Association, the Second Annual Conference for County Medical Society Presidents and Secretaries will convene at the Hotel Robert Meyer in Jacksonville on Saturday afternoon, January 16, and continue through Sunday morning, January 17. The plan to bring together annually the incoming presidents and secretaries of all component county medical societies was initiated in December 1958 and was so well received that an exceptionally large attendance at this second meeting is anticipated.

Dr. Ralph W. Jack, of Miami, President of the Florida Medical Association, will preside at the opening session on Saturday, beginning at 2 p.m. He will welcome the assembly and explain the purpose of the meeting. Subjects to be discussed at this session will include Current Policies and Programs of the American Medical Association, Responsibilities of the County Medical Societies, New Florida Medical Association Charter and By-Laws, Forand Type Legislation and Aging, Florida Medical Foundation, and Florida Medical Association Investment Trust. A question and answer period will conclude the afternoon program.

A reception is planned for 6 p.m. on Saturday and will be followed by a dinner at the hotel.

In response to the request of many who attended the first conference last year, opportunity will be given at the morning session on Sunday for the county medical society officers to discuss their mutual programs and problems. Dr. Leo M. Wachtel, of Jacksonville, President-Elect of the Florida Medical Association, will preside over this concluding session, with adjournment scheduled for noon.

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**The Florida Midwinter Seminar  
Of Ophthalmology and Otolaryngology  
Meets in Miami Beach, Jan. 24-30, 1960**

The Florida Midwinter Seminar of Ophthalmology and Otolaryngology will hold its fourteenth annual session at the Americana Hotel in Miami Beach the week of January 24, 1960. The lectures on Ophthalmology will be presented on Monday, Tuesday and Wednesday, January 25, 26 and 27, and those on Otolaryngology will follow on Thursday, Friday and Saturday, January 28, 29 and 30. The College of Medicine of the University of Florida and the University of Miami School of Medicine are cooperating in the presentation of the Seminar, which has wide popular appeal throughout the nation.

On Wednesday evening there will be the usual social features. All registrants and their wives will be guests at a cocktail party at the Americana at 6:30 p.m. The chief social feature will be the informal dinner at 8:00 p.m.

The lecturers on Ophthalmology and their subjects are: Dr. Bernard Becker, of St. Louis, "Tonography in Diagnosis and Therapy (glaucoma)," "Use of the Newer Secretory Inhibitors (glaucoma)" and "Use of the Newer Miotics (glaucoma);" Dr. David G. Cogan, of Boston, "Ophthalmological Errors That Turn Up in the Pathology Laboratory" and "What Examination of the Eye Tells Us About Systemic Disease" (two lectures); Dr. Robert N. Shaffer, of San Francisco, "Gonioscopy," "Congenital Glaucomas" and "Secondary Glaucoma;" Dr. Joseph A. C. Wadsworth, of New York City, "Vitreous Syndromes," "Tumors of Lid Margins and Their Treatment" and "Differential Diagnosis of Macular Lesions;" and Dr. Frank B. Walsh, of Baltimore, "Bilateral Sudden Blindness," "Ocular Muscles and Systemic Diseases" and "Selected Case Reports."

The otolaryngologists who will lecture and their subjects are: Dr. Lawrence R. Boies, of

Minneapolis, "Indications for Sinus Surgery in the Present Era," "Clinical Observations on the Genesis of the Symptoms of Tinnitus and of Vertigo" and "Neurological Lesions in Otolaryngology;" Dr. Maurice H. Cottle, of Chicago, "Premaxilla-Maxilla Approach to Septum Surgery—A New Operation," "Surgery for Atrophic Rhinitis and Septum Perforations" and "Pressure and Flow Pressure Testing of Nasal Function—Correlation With Nasal Surgery;" Dr. Howard P. House, of Los Angeles, "The Office Management of Common Ear Problems," "The Present Status of Surgery for Otosclerosis" and "Reconstructive Surgery in Chronic Ear Disease;" Merle Lawrence, Ph.D., of Ann Arbor, Mich., "The Symptom: Deafness," "Effects of Middle-Ear Pathology Upon Sound Conduction," and "Acoustic Effects of Middle Ear Reconstruction;" and Dr. Joseph H. Ogura, of St. Louis, "Conservation of Function in Carcinoma of the Larynx," "Treatment of Extensive Cancers of the Larynx, Pharynx and Esophagus" and "Cancer of the Sinuses, Nasopharynx and Mouth and Tongue—Primary and Secondary Repair."

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**Medical Seminars—Spring 1960  
University of Florida College of Medicine**

The Division of Postgraduate Education of the College of Medicine of the University of Florida announces two Medical Seminars for January 1960 and three for February. The first one is a Seminar in Surgery on January 14-16, to be presented under the auspices of the Department of Surgery, Dr. Edward R. Woodward, Chairman. Emphasis will be primarily on surgical problems of head and neck surgery. In addition to departmental staff members the faculty will include Dr. C. Barber Mueller, Professor and Chairman, Department of Surgery, State University of New York College of Medicine, Upstate Medical Center, Syracuse, N. Y., and Dr. Erle E. Peacock Jr., Assistant Professor of Surgery, University of North Carolina School of Medicine, Chapel Hill, N. C.

On January 28 and 29 a Seminar in Physical Medicine, under the direction of Dr. Harriet E. Gillette, Assistant Professor of Surgery in charge of Physical Medicine, will be co-sponsored by the American Academy of Physical Medicine and Rehabilitation. Hemiplegia, ability evaluation, cervical and low back pain, arthritis, steroid therapy in collagen diseases, diseases of the chest, and the



multidiscipline approach to patient management are topics to be discussed. Visiting faculty will include Dr. Miland Knapp, Medical Director, Kenney Rehabilitation Institute, Minneapolis, Minn.; Dr. Frederic Knottke, Professor of Physical Medicine and Rehabilitation, University of Minnesota, Minneapolis, Minn.; Dr. Howard F. Polley, Associate Professor of Medicine, Graduate School, University of Minnesota, Minneapolis, Minn.; and Dr. Charles Shields, Assistant Dean and Chairman, Department of Physical Medicine and Rehabilitation, Georgetown University Medical School, Washington, D. C.

The February seminars begin with a Seminar in Anesthesiology on February 4-6, co-sponsored by the Department of Anesthesiology of the University of Miami School of Medicine. It will be presented under the direction of Dr. Joachim S. Gravenstein of the Department of Surgery, University of Florida College of Medicine, and Dr. J. Gerard Converse, Department of Anesthesiology, University of Miami School of Medicine.

Under the auspices of the Department of Pediatrics, Dr. Richard T. Smith, Chairman, a Seminar in Pediatrics will be presented on February 11-13. There will be detailed discussion of such subjects as clinical problems in mineral and water metabolism in infants and children, dermatologic disorders in children, current knowledge of streptococcal infection and its significance, hematologic problems in children and biochemically determined genetic defects. In addition to local faculty members, out-of-state lecturers will be Dr. Robert E. Cooke, Professor and Chairman, Department of Pediatrics, The Johns Hopkins University School of Medicine, Baltimore, Md.; Dr. Louis K. Diamond, Professor of Pediatrics, Harvard Medical School, Boston, Mass.; Dr. Allan Lorincz, Associate Professor of Dermatology, University of Chicago, The School of Medicine, Chicago, Ill.; and Dr. Lewis W. Wannamaker, Professor of Pediatrics, University of Minnesota School of Medicine, Minneapolis, Minn.

A Seminar in Obstetrics and Gynecology, to be presented under the auspices of the Department of Obstetrics and Gynecology, Dr. Harry Prystowsky, Chairman, is scheduled for February 25-27. Consideration will be given to some commonly encountered obstetric and gynecologic problems. The faculty will consist of departmental staff members and Dr. Nicholson J. Eastman, Professor and Chairman, Department of Obstetrics, The Johns Hopkins University School of

Medicine, Baltimore, Md., and Dr. Louis M. Hellman, Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York College of Medicine, New York, N. Y.

All courses are approved for Category 1 credit by the American Academy of General Practice. Address inquiries to the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

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### **Medicine's Four Freedoms Stressed by Dr. Wachtel**

At the annual meeting of the Medical-Dental-Hospital Bureaus of America, held in Miami Beach in October, Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, was a guest speaker. Dr. Wachtel chose for his subject "The Four Freedoms in Medical Practice." He defined these basic rights as (1) freedom of choice of physician by the patient, (2) freedom of the physician to accept or reject a patient, (3) freedom of the physician to set his own fee, and (4) freedom of the physician to practice within the limits of his ability, training and experience.

The first of these freedoms Dr. Wachtel regarded as by far the most important and also the one most encroached upon and threatened. The patient's right to choose his physician, he said, "is the sine qua non of the successful private practice of medicine as we have known it in America from its colonial beginning and is held as sacred to the democratic way of our lives as is the freedom to worship as we please or vote for whom we please." He deplored third party intervention, adding that it must be contained for the benefit of the public, and declared the abrogation of the right of the individual to choose his own physician to be "as un-American as any of the 'isms' which are repugnant to us." He also condemned the Forand Bill, still a live issue before the Congress, as a particular threat to the free choice principle.

Dr. Wachtel stoutly defended the freedom of a physician to accept or reject a patient and also the physician's right to set his own fees. "Just as life, liberty, and the pursuit of happiness have always been the inalienable right of free men in this great nation," he maintained, "so has the right to set his own fee for his services been the right of the physician from time immemorial."



Any doctor who takes unfair advantage of this freedom soon finds that public policy in the community in which he serves will react to his poor public relations by diminishing his practice, unless he has already previously been called to task by a jury of his peers—the medical society.”

Likewise, Dr. Wachtel vigorously upheld the fourth freedom, the physician's right to practice within the limits of his ability, training and experience. He pointed out that general practitioners are the backbone of medical practice. Citing an estimate that the well trained general practitioner is capable of handling 85 per cent of the complaints presented to him and convinced that 99 per cent of such physicians recognize their limitations and know when to refer patients, he emphasized that they “should not be hobbled by arbitrary restrictions based on malice, professional jealousy, or economic considerations.” He noted that there is wide variation throughout the country as to the degree to which this freedom is trampled upon, depending on the size of the town or the hospital and the degree to which specialization has occurred within the profession.

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### **Central Florida Medical Meeting Orlando, March 12, 1960**

Plans are being formulated for the Sixth Annual Central Florida Medical Meeting, sponsored by the Orange County Medical Society, which will be held in Orlando on Saturday, March 12, 1960, with headquarters at the San Juan Hotel. Plans are being made so that approval by the American Academy of General Practice for six hours' credit, category I, may be made possible as in the past. It is believed that this meeting will appeal to general practitioners throughout Central Florida and other surrounding counties. There will be five speakers in the following fields of medicine: Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, and Orthopedics.

It is anticipated that the luncheon will be held separately for the ladies and the men, with the ladies having the opportunity of viewing a fashion show. Following the conclusion of the afternoon scientific session, a social hour has been planned to be followed by a banquet and an outstanding after-dinner speaker. Plans will be greatly facilitated if physicians would mark this date on their calendar now and make plans to attend this Sixth Annual Central Florida Medical

Meeting on Saturday, March 12, 1960, at the San Juan Hotel in Orlando.

Dr. James B. Glanton is chairman of the arrangements committee. Mrs. Thomas D. Cook is chairman of the Woman's Auxiliary committee.

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### **American Cancer Society, Florida Division Participates in Epidemiologic Study of Cancer**

As reported in the July 11, 1959 issue of the Journal of the American Medical Association, the American Cancer Society is undertaking a large scale study of cancer in relation to various environmental factors. The plan is to enroll about 500,000 families nationwide of which about 30,000 families will be enrolled in 42 Florida counties beginning on October 23. Dr. Joseph Zavertnik, President of the Florida Division of the American Cancer Society, announced. Volunteer workers of the society will be used to enroll families in which there is at least one person over the age of 45 and then request every member who is over the age of 30 to fill out a questionnaire. In order to keep the information confidential, each subject will put his filled-out questionnaire in an envelope and seal it before returning it to the volunteer for transmittal to the research center. The volunteers will not interview the subjects and will not see the completed questionnaires.

The subjects will be followed annually for six years to determine which of them die in this interval. Causes of death will be ascertained from death certificates. When cancer is mentioned on a death certificate, the physician who reported it will be requested to supply additional medical information, such as the histologic type and the stage of the disease at the time of diagnosis.

The major purpose of the study is to ascertain the association, if any, between various environmental factors, such as occupational exposures, habits, diet, and factors related to the breast and female genital organs, and the later occurrence of cancer. It is hoped that this information will yield clues as to a number of possible causes of cancer.

In addition, it is hoped that the study will provide information of value in relation to lay education. The subjects are asked detailed questions about “present physical complaints,” and the answers will be analyzed in relation to causes of cancer diagnosed in the subsequent several

months. In order to avoid biasing the subjects, questions are asked about physical complaints which are probably not related to cancer as well as about complaints which may be symptomatic of cancer. Assuming, as is possible, that positive answers to certain of these questions are highly related to the presence of cancer, the data should be of value in persuading persons with such complaints to see their doctor immediately. The aim, of course, is to reduce the factor of "patient delay" in the diagnosis of cancer.

Physicians desiring more information about the survey are advised to contact their local unit of the American Cancer Society or the Florida Division, American Cancer Society, 416 Tampa Street, Tampa 2.

### LETTER TO THE EDITOR

September 11, 1959

Dear Dr. Richardson:

Although the price for reaching maturity is a painful realization that perhaps childish enthusiasm is a thing of the past, it has seemed easier for me to accept ideas provided I maintain an open discriminating mind, not one so fixed by dogma and convention that it blinds vision to the possibilities offered. For this reason, I have enjoyed travel and the opportunities it offers to make personal contacts with surgeons in all parts of the globe and from this fact I have learned that we often become too satisfied with what we accept as proved theories and technics, and too complacent in an approach to a new idea to the extent that it is difficult to see virtue in new conceptions that "far-off foreigners" have to offer in regard to treatment of many problems in our own specialties.

In 1948 I went to Europe to seek out Professor Albin Lambotte. This man wrote a book called "The Operative Treatment of Fractures," first published in 1913. For me it is still the epitome of reference and the best book on fundamental principles of fracture treatment. It was never published in English. Professor Lambotte visited New York in 1917; he spent only a few days there and performed an open reduction on a femur in about 25 minutes. He was not accepted very hospitably, although his operation was performed, as he spoke only French. His visit was disappointing to him, and he returned to Belgium rather unhappy with his first and only

trip to the United States. Professor Lambotte was orthopaedic surgeon to King Albert and was a personal friend of Astrid, Queen of Belgium. He was a violin maker by avocation, and the violin which he made for me and which I often play is held by me as my prize possession in the memory of a great man whom few Americans ever learned to know. I hold in my library the original copy of his first book written in French, which I am well able to use for a reference book at any time I find a difficult problem in fracture treatment. To this day, this very well written and informative volume has never been translated into English.

The external fixation of fractures was accomplished by Professor Lambotte as early as 1898. In my library I hold photographs of his first cases to prove the point. Hardly anyone paid much attention to this valuable method of treatment until it was revived by Dr. Roger Anderson of Seattle during World War II.

In 1943 I read about the fixation of fractures of long bones with an intramedullary rod. In 1950 I set out to search for Professor Gerhard Küntscher. Even those who had studied under him in Germany could not tell me where I could find him, but finally I located him in a small town called Schleswig near the Danish border. His name is well known throughout the world of traumatic surgery. I visited him on four occasions in his hospital over a period of six years before I finally understood the intricate technic which is actually the Küntscher technic and seldom, if ever, practiced in this country. My feelings about Professor Küntscher are expressed in my discussion of his paper at the meeting of the American Academy of Orthopaedic Surgeons in 1957:

"You have heard the words of the master, who in a very short time has given you food for thought. You have seen again that to know the metal does not entitle you to know the method or the man. One cannot expect good results from bad technique and certainly the technique as you have seen it today has never been described in the English literature purely and unadulterated. The experience of Professor Küntscher has been well known, but the precision of the method has not. Having seen his work and the excellent results, I urge you to reconsider his ideas and stimulate others to do so. Today, you have seen evidence as against rumor—facts as against gossip.

"The solution of many professional problems could be accomplished by international coopera-



tion and coordination. Key problems are being studied simultaneously in many countries and often research men cover ground that has already been investigated. Would it not be much more rational both from the standpoint of each country and world scientific progress to coordinate this work? Where is cooperation more possible on the widest scale than in the care and treatment of human ills? I can assure you that it is not only a privilege and a pleasure to have had the opportunity to discuss the paper of Professor Gerhard Küntscher, but it is an outstanding event of one's lifetime to have been able to bring him before this eager and intelligent audience."

Even then to present this great man to the American Surgeons became possible only at great personal expense. It was never possible to have him invited as a guest of any of these large organizations, the reason given being that Professor Küntscher's English could possibly not be understood by all of those attending in the audience. For me it has been a pleasure many times just to look upon a famous personality, whether he be Hungarian, Yugoslav, French or Russian. This is the pulse of the profession to which one dedicates his life.

Recall that the first people who used intramedullary fixation methods were practically accused of promoting barbarism and cruelty, and for a while it was considered almost malpractice to consider the use of a steel rod in the middle of a bone, but the results soon proved their usefulness.

Dr. James E. M. Thomson as President of the American Orthopaedic Association has been responsible for bringing many famous orthopaedic surgeons to the United States. His invitation to Professor Frejka of Brno, Czechoslovakia brought on the description of the pillow for congenital dislocations and hip dysplasias, first in 1947. This was looked upon with scepticism by the well trained young, as well as the greying stoics, of the conventional, forceful reduction and long-continued plaster cast methods used so generally, and yet, today, the gentle method of a modest Czechoslovakian professor is accepted.

Twice I have visited Professor Gruca in Warsaw, Poland, and have followed his cases in the use of metal springs as a substitute for weakened muscles in scoliosis. He demonstrates hundreds of remarkable corrective results in carefully selected cases. Though the equipment is available, we shrink from trying it. Is it the fact that we fear

medical negligence actions as a legal sword over the doctor's head?

It was my pleasure to see a 70 year old man who for several years was pitifully disabled with a painful osteoarthritis of his hips. He was operated on successfully by the Pauwels adduction osteotomy, now has practically a full range of motion, and to his delight is free of pain. He walks without support. True, he still has a positive Trendelenburg limp, but he had this limp before the operation and he got around only on crutches. The words "adduction osteotomy" in orthopaedic circles, with the exception of a few men who have studied in foreign countries, is almost a profane expression; yet I can show slides of a dozen or more cases of patients well pleased with this method which, to American surgeons, deviates from all principles. Perhaps by another generation its effectiveness will be introduced and proved.

These are but a few of the contributions from foreign countries which take a long time to sink into the world-ruled conventional approach which our specialty often assumes. Every country in the world has surgeons who have ingenious ideas and interesting technics. Yes, even in Russia I saw some and when I returned from Russia in 1956, I quickly learned that to mention anything good about that visit was to bring upon myself severe criticism.

One of the best organized services in orthopaedic surgery with the highest standard of work that I have ever witnessed in my trips to 32 countries was the orthopaedic service superbly managed under the able direction of Professor B. Boytchev with Assistant Professors Boris Conforty and K. Tchokanov. Their services are staffed by three hospitals in and around Sofia, Bulgaria. My truthful impressions were quoted in the magazine called "Bulgaria Today," issued in 1959, and I repeat them without reservation: "In the specialty of orthopaedic surgery I can say that here I have seen techniques which were not known to me before. Your surgeons can claim positions with the highest anywhere. Your young men in the profession have an incentive unexcelled in any country that I have visited."

One of the best textbooks on orthopaedics and traumatic surgery available in any language is the book of Professor Boytchev. Here, one can find the rare combination of Eastern and Western surgery which includes Oriental technics, and it is the only book of its kind in which I have ever



seen this rare combination. It is so well illustrated that one need not be familiar with the Bulgarian language to use it as a reference text.

My advice, then, to the traveler is always to stop, look and listen, and he will always learn something worth while.

I hope that in this resume I have fulfilled my purpose to convince the members of the Florida Medical Association that travel is rewarding and that they, too, can make similar contributions in time and effort and understanding by facts of sincerity and integrity which will convince our colleagues in other lands that professional men have a long record of idealism and a sense of values which has made them dedicate themselves to the saving of life, not its destruction.

Our Oath of Hippocrates is recognized by doctors throughout the world and it sets the pattern for our professional ideal and our relationship to our fellow man.

Respectfully submitted,  
Irwin S. Leinbach, M.D.

### OTHERS ARE SAYING

Christmas, 1958

"God rest you merry, gentlemen,  
Let nothing you dismay."

So sang the waits of London when this beloved carol was set to an old Gregorian chant in the eighteenth century.

There was much to cause dismay at the time. The North American colonies, save for Canada, had been lost, revolution had shaken France to the roots, and there was incubating across the channel a dictator who would pose the worst threat since the Spanish Armada, more than a century earlier.

But great things were afoot among the shadows.

Newton had propounded the law of gravitation, Jenner had vaccinated against smallpox, and William and John Hunter had laid the groundwork for anatomic and clinical investigation.

In our own century revolutions continue to shake the world. A new dictatorship, armed with unbelievably destructive ideas and weapons, threatens.

Nevertheless, good works go on. We have had our Einstein and the theory of relativity. We

have our Salk and Papanicolaou. At mid-century we are fully embarked on the Age of Imagination. Things formerly wildly dreamed of are in the process of accomplishment.

The carol has deep religious meaning that can be shared by all. It sings of the natal day of One Who taught that there is dignity and meaning in the life of everyone and that prejudice, fear, and hostility can be replaced by love in the hearts and minds of men. We need to hold to these truths now more than ever before in history.

As the carol ends on the note of comfort and joy, so our Christmas wish for you is that you may be a comfort to your patients and a joy to your family and friends.

*New York State Journal of Medicine*  
December 15, 1958

BLUE




SHIELD

### Is Medicine A "Noble" Profession? Are Doctors Different?

"I know 'Ours is a noble profession' and all that, but that is a cliché of the past and not honored in the minds of the public today. . . . Ours is no longer a noble profession save in our own eyes." This deflating deduction, among others similarly disturbing, was submitted to Dr. Robert E. Zellner, the Chairman of the Committee of Seventeen, by a member of the Association who is also a Blue Shield Participating Physician.

This physician took the time to voice his sincere opinions directly to those who give of their time freely to study means whereby the medical profession, through its Blue Shield program, may tend to obviate such an unwholesome attitude. Because of this sincerity, and because he is not alone in this viewpoint, the Blue Shield Board of Directors believes that the analysis of the Chairman of the Committee of Seventeen might be helpful to other physicians called upon to answer similar questions from professional or lay sources. He put it this way:

"Let me say first that asking questions is easy. He who asks questions and stops there assumes no responsibility whatsoever. Once one begins to offer answers to questions, he not only assumes a responsibility, sometimes a grave one, but he also steps into the arena of controversy."



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.  
2. Ferrand, P. T.: Minnesota Med. 41:853 (Dec.) 1958.  
3. Mathews, F. P.: Am. J. Psychiat. 114:1034 (May) 1958.

**SEARLE**



## brightens life for the aged

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Continuing, he delved into the contention that the medical profession may no longer be held in high esteem by the public.

"As to our 'noble' profession," he replied, "I am convinced that ours is a truly noble profession and that it is so regarded by the vast majority of people. It is noble not because the acquisition of an M.D. degree makes a man noble, but because a lifetime spent in dealing intimately with people and their most confidential problems and of being completely trusted by others brings out the best in any man. If we are regarded as less than noble, we have no one to blame but ourselves in not acting in a manner meriting high regard. When we insist on the prerogatives . . . of pay me first, or I don't care how you pay for it, that's my price, or I'm going fishing, call another doctor, then we should not find it hard to understand when we begin to fall in public estimation. Now, I am convinced that you, that I and that most doctors have a greater sense of responsibility than to act in such a manner; but there is a sufficiently significant number of doctors in your community and in mine who don't have such a feeling that it colors the public opinion of all of us."

As to the second big factor disturbing this correspondent, the apparent discrimination when compared with other vocations, this interpretation was offered:

"You ask why should doctors be considered different from other people. My answer is that it is because we are different. Did you know that doctors of all the citizenry are the only people exempt from jury duty? Why? Because it is considered that our work is too important and too essential *to the community* (not to the

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# PLAN AHEAD

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BALMORAL HOTEL

April 27th to 30th, 1960

*For details write:*

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doctor) to permit us to spend our time in such a manner. Recently, one of the wealthiest men in Central Florida, the operator of a million dollar business, spent two weeks on jury duty at five dollars a day fulfilling one of his obligations as a citizen; yet, had he been the rawest intern, he would have been exempt on the grounds that he had more important work to do. So, we are different, and the community so regards us.

"There is another way in which we are different. The practice of medicine is a public trust. No doctor ever pays for his medical education. For every dollar he spends toward his own education either some philanthropic person or the government spends three. Because a medical education is a privilege rather than a right, we have imposed upon us a responsibility to the public for granting us that privilege. And how is this different from the practice of law, architecture, engineering, et cetera? Well, it's a matter of degree. A medical education is many times more expensive and the selectivity is greater. As you know, many are called but few are chosen; so the chosen do have a greater responsibility."

The initiating assumption, which stimulated the correspondence, that the medical profession is being called upon to shoulder an unproportion-

ate share in the care of the aged provoked this observation from the Chairman:

"No doubt you are wondering what all this has to do with the taking care of the aged. Just this: We have now, as we have always had, the obligation to take care of all those who need medical care, those who can afford it as well as those who can't. With the advent of pension plans, retirement income insurance and social security, the sharp line which once existed between those on the dole and those able to pay their own way has disappeared. In recognition of this fact a new term has found its way into our language, "medical indigents," people who can get along day to day provided they don't get sick. An ever increasing percentage of people in this category is made up of those people over 65 years of age. We have the same responsibility to take care of these folk now as we had last year, twenty years ago, or one hundred years ago. If they are capable of paying part of their way, then we should have the same interest that doctors have always had in preserving human dignity to help them to find a way to do it. I do not believe that a man should be *made* to accept free treatment as an indigent if he can partially pay his own way."

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MYOGESIC<sup>x</sup>

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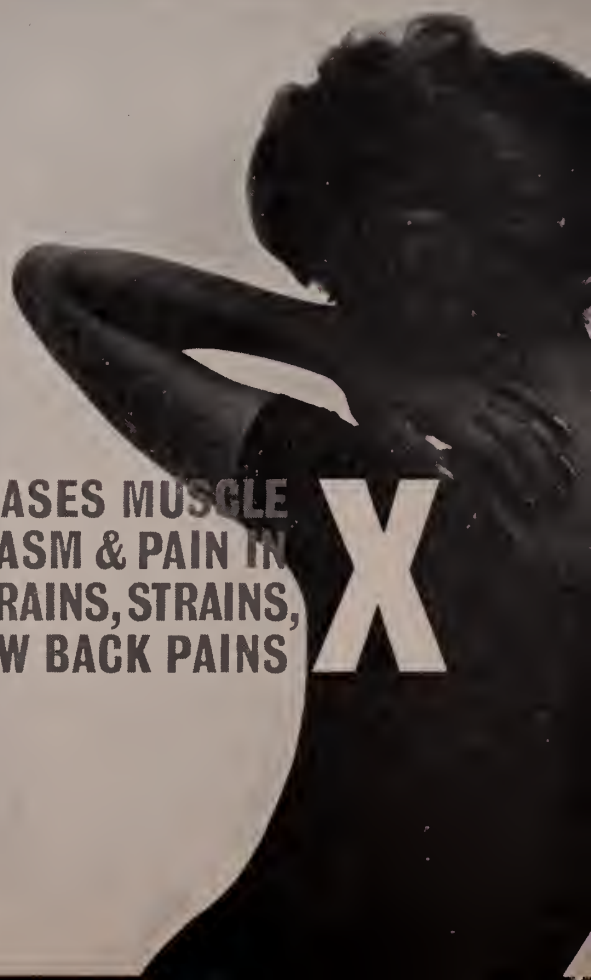
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LOW BACK PAINS

**X**

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## STATE NEWS ITEMS

The Mid-Winter Meeting of the Florida Obstetric and Gynecologic Society is being held Friday, Saturday and Sunday, December 4-6, at the Colony Hotel at Palm Beach. The scientific program begins Saturday morning at ten o'clock with a discussion of case reports by panel members Dr. Dennis Cavanagh, Miami, Assistant Professor of Obstetrics and Gynecology, University of Miami School of Medicine; Dr. Hugh Hill, Gainesville, Assistant Professor of Obstetrics and Gynecology, College of Medicine, University of Florida; Dr. Charles J. Collins, Orlando, and Dr. T. Vernon Finch, Sarasota. Case reports include "Repeat Ectopic Pregnancy" by Dr. James R. Sory; "Incompetent Cervical Os" by Dr. Thomas J. Valin and Dr. Theodore F. Gerson; "Granulosa Cell Tumor of the Ovary" by Dr. Samuel A. Manalan; "Subacute Bacterial Endocarditis" by Dr. Daniel H. Rowe and Dr. Jack Fealy; "Ruptured Uterus" by Dr. Maximilian A. Crispin, and "Prednisone Therapy in Infertility" by Dr. George J. Nassef. All physicians presenting cases are from the West Palm Beach area.

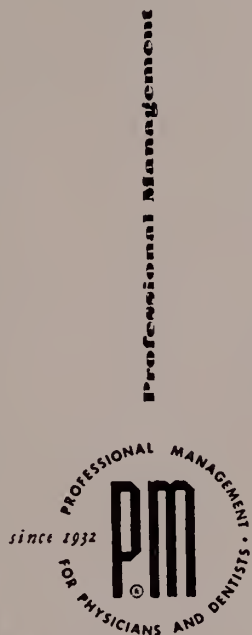
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## *Announcing* The Twenty-Third Annual Meeting of THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY Conference Headquarters — Roosevelt Hotel March 7, 8, 9, 10, 1960

### GUEST SPEAKERS

Leroy D. Vandam, M.D., Boston, Mass.  
Anesthesiology  
Clarence S. Livingood, M.D., Detroit, Mich.  
Dermatology  
Henry D. Janowitz, M.D., New York, N. Y.  
Gastroenterology  
John G. Walsh, M.D., Sacramento, Calif.  
General Practice  
E. Stewart Taylor, M.D., Denver, Colo.  
Gynecology  
Charles H. Burnett, M.D., Chapel Hill, N. C.  
Internal Medicine  
Peter C. Gazes, M.D., Charleston, S. C.  
Internal Medicine  
Donald D. Matson, M.D., Boston, Mass.  
Neurosurgery  
Frank R. Lock, M.D., Winston-Salem, N. C.  
Obstetrics

Trygve Gundersen, M.D., Boston, Mass.  
Ophthalmology  
Carroll B. Larson, M.D., Iowa City, Ia.  
Orthopedic Surgery  
John J. Conley, M.D., New York, N. Y.  
Otolaryngology  
W. A. D. Anderson, M.D., Miami, Fla.  
Pathology  
Franklin H. Top, M.D., Iowa City, Ia.  
Pediatrics  
Raymond J. Jackman, M.D., Rochester, Minn.  
Proctology  
David G. Pugh, M.D., Rochester, Minn.  
Radiology  
Bentley P. Colcock, M.D., Boston, Mass.  
Surgery  
Robert M. Zollinger, M.D., Columbus, Ohio  
Surgery  
George C. Prather, M.D., Brookline, Mass.  
Urology

Lectures, symposia, clinicopathologic conferences, round-table luncheons,  
medical motion pictures and technical exhibits.

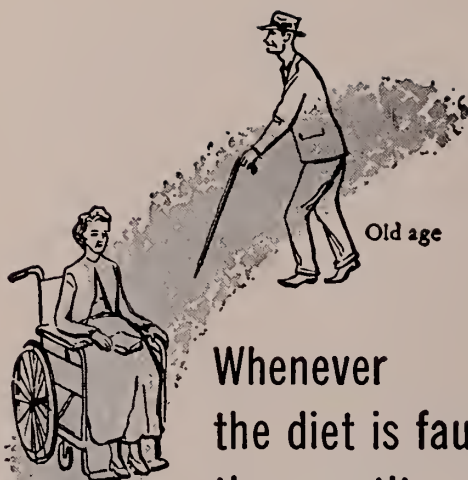
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Leaving March 12 from Port Everglades, Florida, and returning March 25, 1960.

For information concerning the Assembly meeting and the cruise write  
Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.





Old age

Convalescence



Adolescence



Infant diarrhea

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gastrointestinal  
conditions

Postoperatively

Whenever  
the diet is faulty,  
the appetite poor,  
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is excessive

*through vomiting  
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## Valentine's MEAT EXTRACT

stimulates the appetite,  
increases the flow of  
digestive juices,

provides: supplementary  
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and soluble proteins,

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potassium therapy.*

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RICHMOND 21, VIRGINIA

Sunday morning Dr. James H. Ferguson, Miami, Professor and Chairman, Department of Obstetrics and Gynecology, University of Miami School of Medicine, will present a paper entitled "Correlation of Cytology and Histopathology Reports in Cervical Disease," and Dr. Harry Prystowsky, Gainesville, Professor and Chairman, Department of Obstetrics and Gynecology, College of Medicine, University of Florida, will discuss "A Trip into Space." The meeting adjourns at noon.

Officers of the Society include Dr. Homer L. Pearson Jr. of Miami, president; Dr. T. Bert Fletcher Jr. of Tallahassee, president-elect, and Dr. Sam W. Denham of Jacksonville, secretary-treasurer.

Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, participated in ceremonies as the principal speaker at the recent dedication of the new hospital at Lakeland.

Dr. Herbert L. Bryans of Pensacola, a Past President of the Florida Medical Association, officially represented the Association at the Gulf Coast Clinical Society meeting in Mobile October 22.

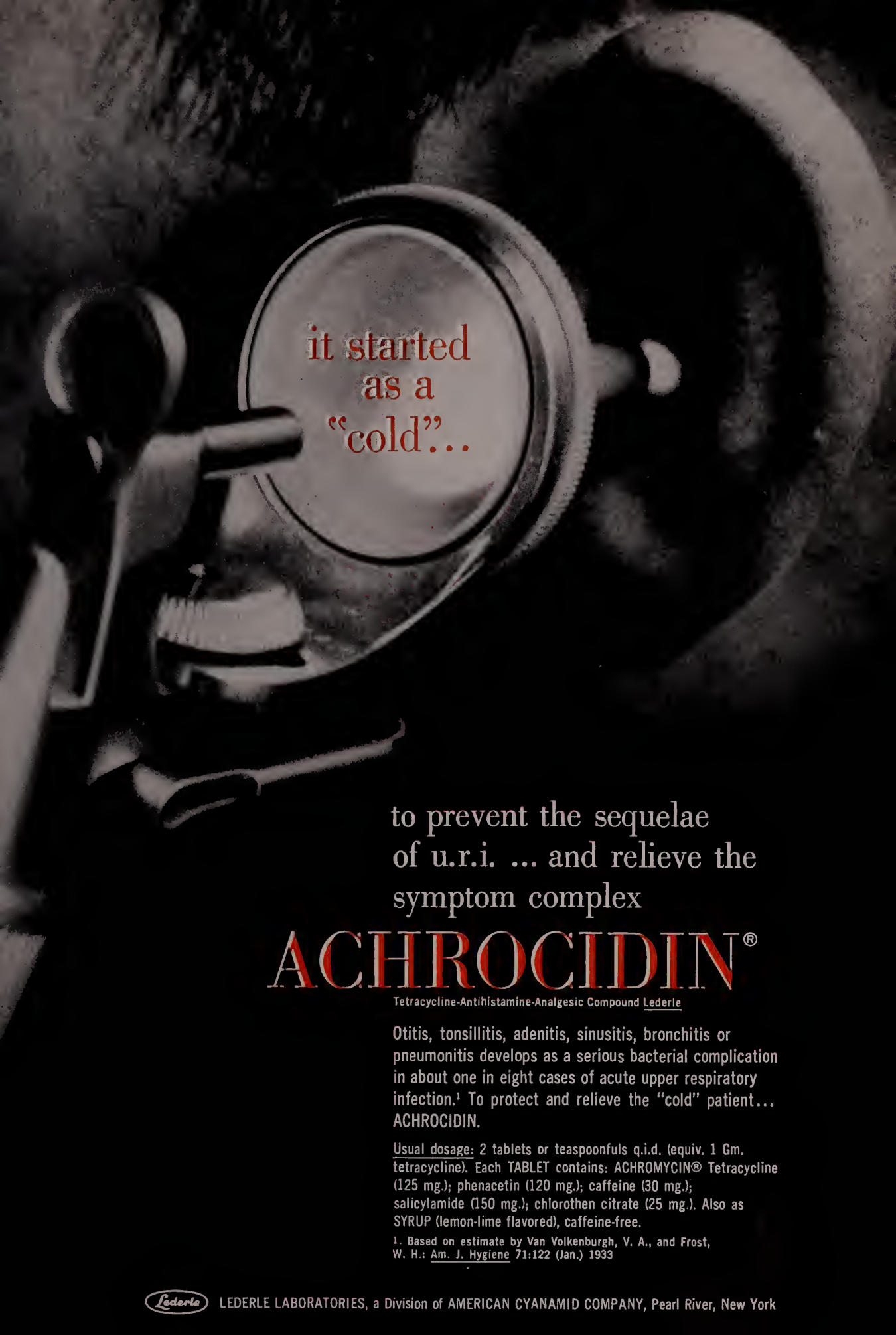
Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, discussed "The Four Freedoms in Medical Practice" at the 21st Annual Convention of the Medical-Dental-Hospital Bureaus of America held at Miami Beach October 20-24.

Dr. Wilson T. Sowder of Jacksonville, state health officer, has been elected president of the Association of State and Territorial Health Officers.

The University of Miami School of Medicine has received a grant of \$446,000 from the John A. Hartford Foundation of New York for a three year research project in perfusion. The program combines surgery, chemistry and electronics for the long term perfusion of isolated organs in man, for the investigation and therapy of a variety of chronic diseases such as cancer, arteriosclerosis, arthritis and neurologic disorders.

Dr. Edward R. Woodward of Gainesville, Professor of Surgery at the College of Medicine, University of Florida, has been appointed a member

*(Continued on page 742)*



it started  
as a  
"cold"...

to prevent the sequelae  
of u.r.i. ... and relieve the  
symptom complex

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<sup>1</sup>. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



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\*Hirsch, H. A., and Finland,  
*New England J. Med.* 260:1  
(May 28) 1959

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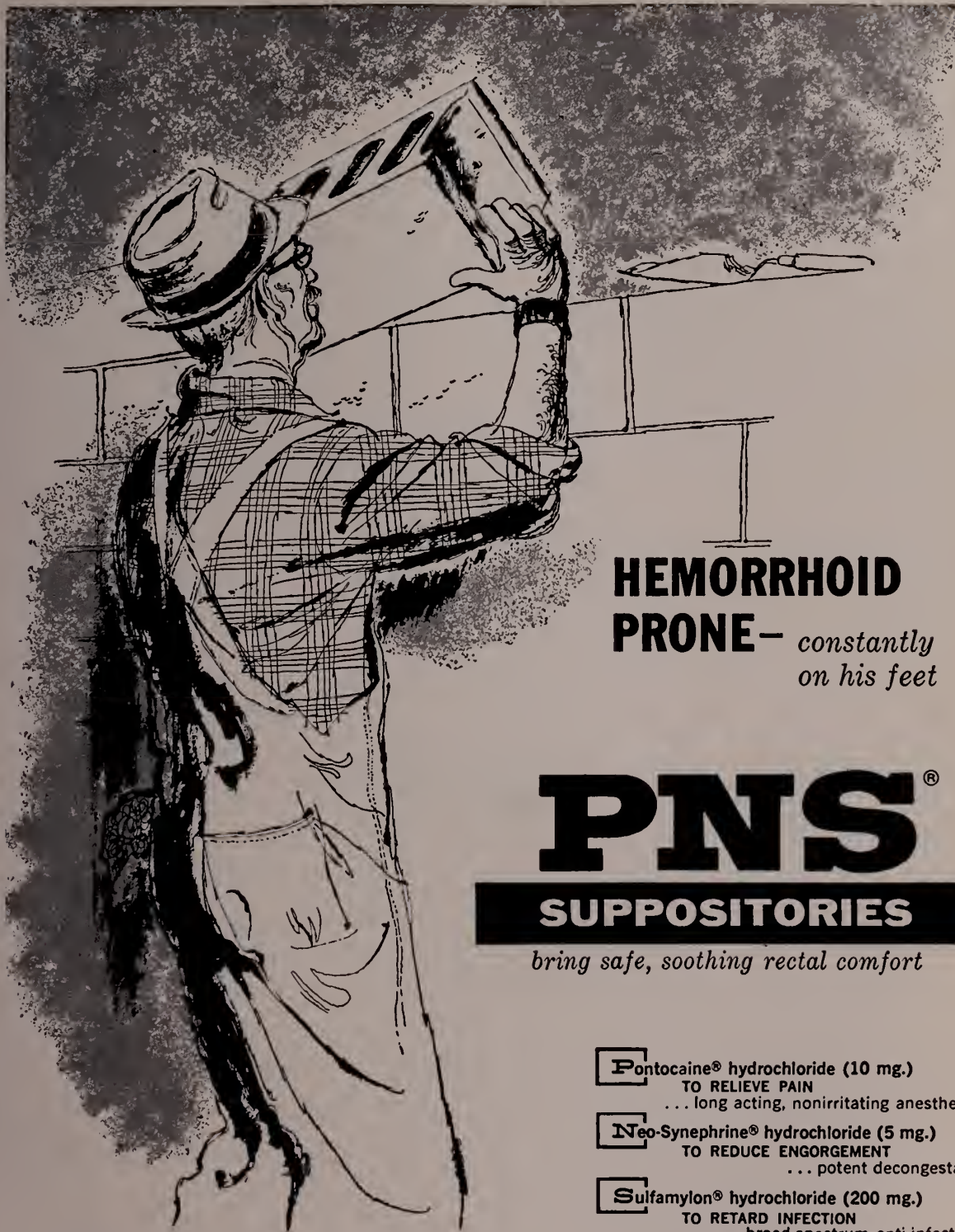
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**Directions:**  
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(Continued from page 736)

of the Committee for the Forum on Fundamental Surgical Problems of the American College of Surgeons. Dr. Woodward has been elected to membership in the Halstead Society which recently held its 33rd annual meeting in Minneapolis.

Dr. Lawrence C. Manni of Tallahassee has been appointed director of the State Tuberculosis Board.

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, addressed a meeting of physicians in the Dunedin area held in the Conference Room at the Mease Clinic the middle of October.

Dr. Nathan Glover of Miami participated in the scientific program of the recent annual meeting of the American Society of Anesthesiologists held at Miami Beach. He presented a paper entitled "The Circulation Time During Surgery and Anesthesia."

Dr. N. Worth Gable of St. Petersburg has been elected president of that city's Emmett Kel-

ly Tent, Circus Saints and Sinners of America. Dr. Paul F. Wallace is a member of the board of directors, and Dr. Clyde O. Anderson is a trustee. Both are from St. Petersburg.

Drs. Nicholas A. Tierney of Miami Beach, and Paul W. Boyles, Franz H. Stewart, William M. Straight, Robert S. Litwak and John C. Turner of Miami appeared on the program of the Southeastern Regional Meeting of the American College of Physicians held at Columbia, S. C., October 30-31.

Drs. Harold O. Hallstrand and Claude G. Mentzer of Miami, Dr. Lester J. Schultz of St. Petersburg Beach and Dr. Charles H. Lasley of Clearwater were among the group of Florida physicians attending the recent annual congress of the North American Federation of the International College of Surgeons held at Chicago.

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, participated in the "Symposium on Current Clinical Medicine," held November 6 at Dallas, sponsored by the Dallas Chapter of the American



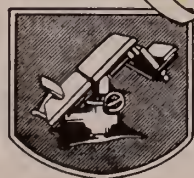
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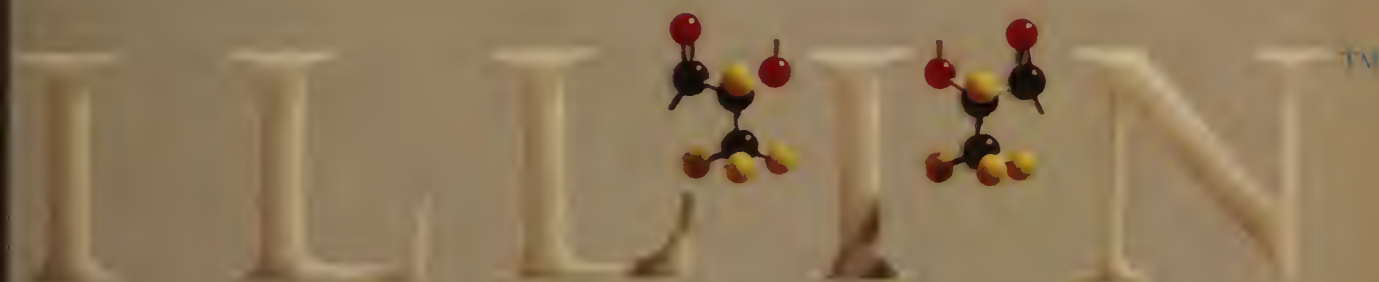
*SAFER ORAL ROUTE  
PROVIDES HIGHER  
BLOOD LEVELS THAN  
INTRAMUSCULAR  
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*IMPROVED  
ANTIBIOTIC  
EFFECT FROM  
COMPLEMENTARY  
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*ANTIBIOTIC  
ACTIVITY  
DIRECTLY  
PROPORTIONAL  
TO ORAL DOSE*

*REDUCED HAZARD  
OF SERIOUS  
ALLERGENICITY  
BY SAFER  
ORAL ROUTE*

*MANY  
STAPH STRAINS  
MORE  
SENSITIVE TO  
SYNCILLIN*



# ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

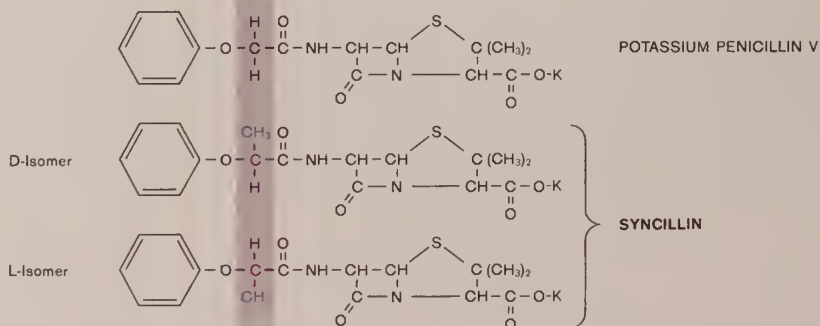
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and  $\alpha$ -phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.<sup>1</sup>

## SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH<sub>3</sub> group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH<sub>3</sub> group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.



# SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

# ISOMERIC COMPLEMENTARITY DEMONSTRATED *IN VITRO*

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against *Salmonella*, *E. coli*, and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1  
Minimum Concentrations of SYNCILLIN and Components  
Required to Inhibit a Wide Range of Bacteria

	Minimum Inhibitory Concentration (MIC) in Micrograms per Milliliter		
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.3
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.5
Corynebacterium xerosis	0.06	0.125	0.3
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0.125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0.06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0.06
*Streptococcus pyogenes Digonnet	0.03	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0.06	0.06
Vibrio comma	50	25	2

Sensal dilution technique in heart infusion broth \*10% serum added

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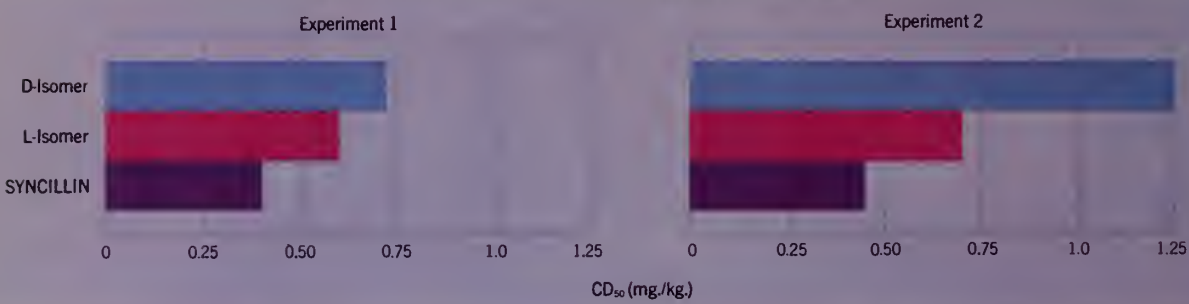




# ISOMERIC COMPLEMENTARITY CONFIRMED *IN VIVO*

To determine the median curative dose ( $CD_{50}$ ) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose ( $CD_{50}$ ) for *Staphylococcus aureus* (var. Smith) Infections

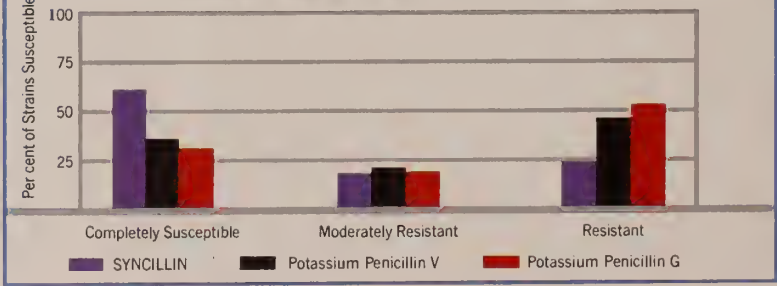


## MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright<sup>2</sup> performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 — *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources



Adapted from Wright<sup>1</sup>

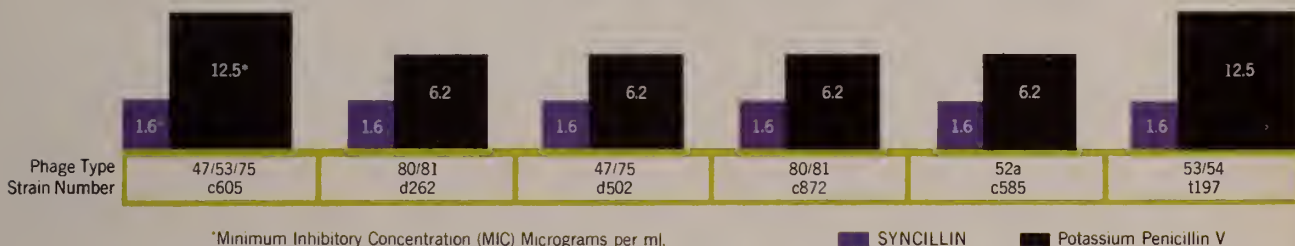
SYNCILLIN

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Of equal interest are the findings of White.<sup>3</sup> Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

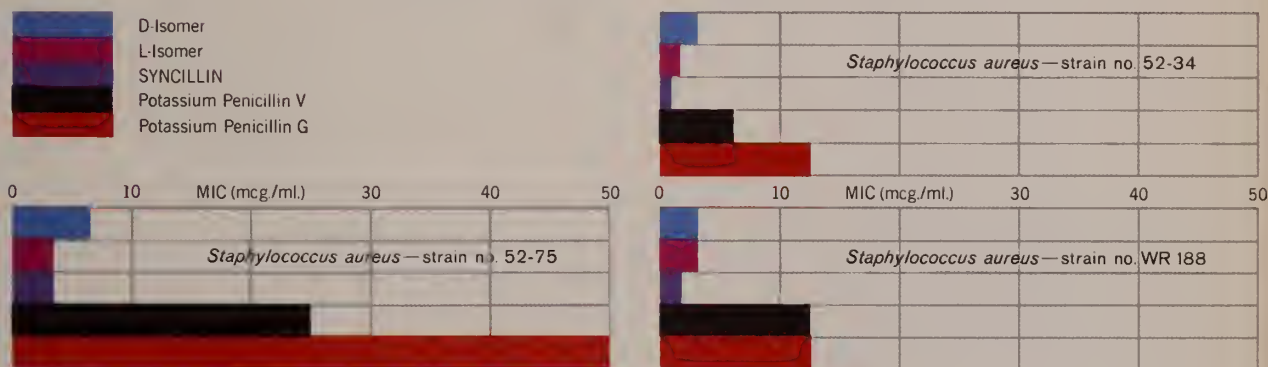


The efficacy of SYNCILLIN against the type 80/81 *Staphylococcus* (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

- certain penicillin-susceptible streptococci, staphylococci and corynebacteria in vitro (Table 1)
- penicillin-susceptible staphylococci in vivo (Figure 1)
- penicillin-resistant staphylococci in vitro (Figure 4)

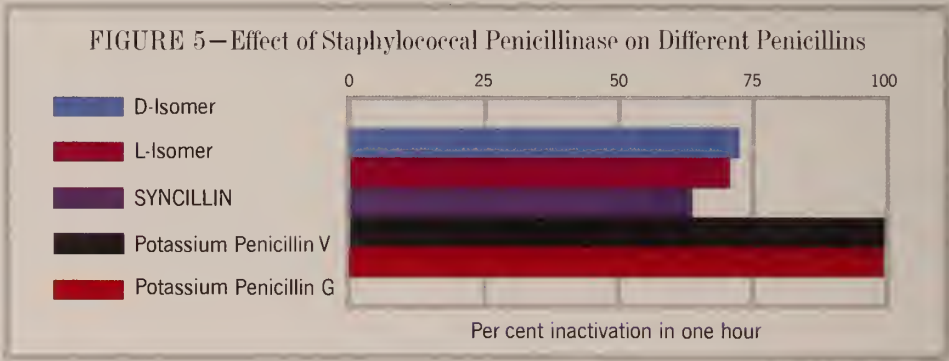
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# ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

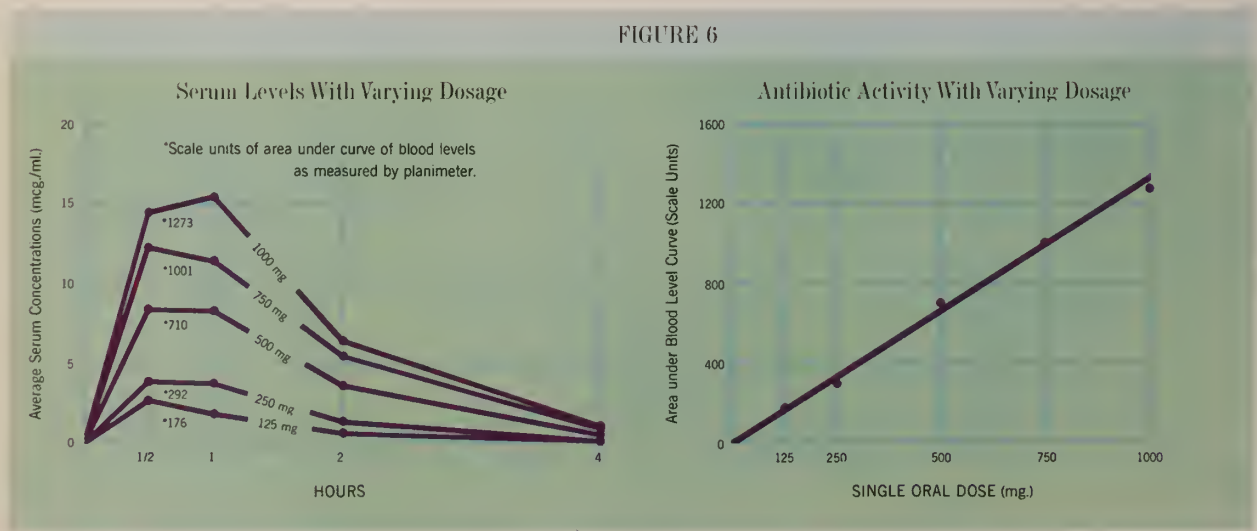
Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.<sup>4</sup> As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.



## ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

Cronk<sup>5</sup> studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.



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# BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright<sup>6</sup> performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.<sup>7</sup> Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

## BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN<sup>6</sup> are much higher than those with intramuscular penicillin G.<sup>8a, b</sup> (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal*, these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 7  
20 Subject Crossover  
250 mg. Single Dose

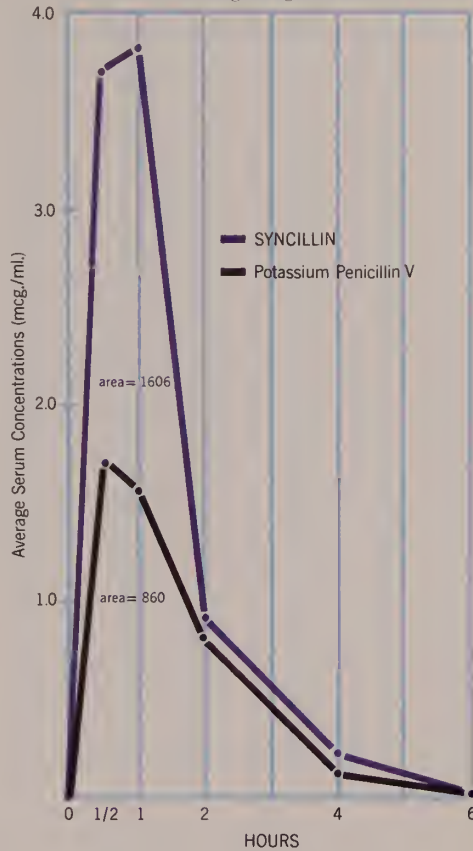
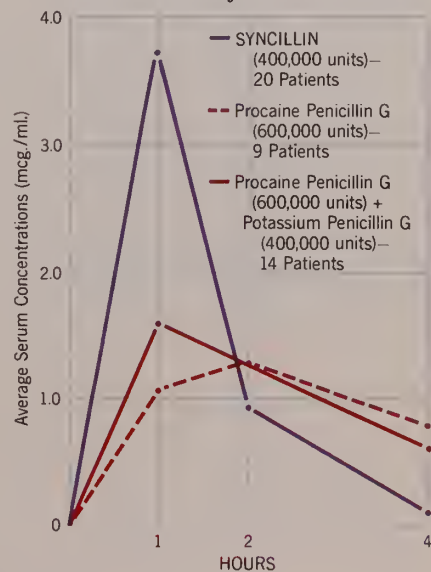


FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



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# REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

As Flippin<sup>9</sup> recently stated, “. . . it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted. . . . In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment.”

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.<sup>10</sup>

## CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,<sup>11</sup> White,<sup>12</sup> Prigot,<sup>13</sup> Robinson,<sup>14</sup> Dube,<sup>15</sup> Ferguson,<sup>16</sup> Rutenburg,<sup>17</sup> Richardson,<sup>18</sup> Bunn,<sup>19</sup> Cronk,<sup>5</sup> Kligman,<sup>10</sup> and Yow<sup>20</sup> demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.

Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus and which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

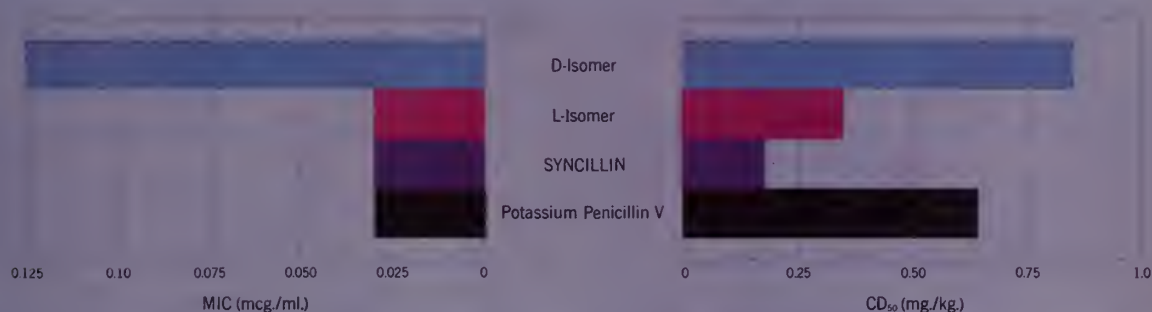
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

## IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers (SYNCILLIN) is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN (*one-third that of penicillin V*) was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9 — Comparison of  $CD_{50}$  and MIC Values Against *Staphylococcus aureus* (var. Smith)

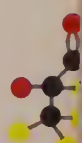


*Isomeric complementarity has thus been demonstrated for:*

- certain penicillin-susceptible streptococci, staphylococci and corynebacteria *in vitro* (Table 1)
- penicillin-susceptible staphylococci *in vivo* (Figures 1 and 9)
- penicillin-resistant staphylococci *in vitro* (Figure 4)
- staphylococcal penicillinase antibiotic inactivation (Figure 5)

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### Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

### Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

### Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

### Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

**References:** 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. 18:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. 62:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, L. M.: Clinical report to Bristol Laboratories Inc.



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SYNCILLIN



Academy of General Practice. On November 8 Dr. Wachtel extended official greetings from the Association to the Florida Rehabilitation Association in session at Jacksonville.

Dr. Robert B. McIver of Jacksonville, a Past President of the Florida Medical Association, has returned from an extended tour of various European countries where he visited clinics and hospitals.

Physicians from the Miami area attending the recent meetings of the American Academy of Ophthalmology in Chicago included Drs. Edward W. D. Norton; H. Carlton Howard; Felix de la Vega; Harry Howich; John F. McKenna; Henry Cadan; Mariano C. Caballero; Collins W. Swords Jr.; James R. Chandler and Manuel A. Schofman.

Dr. Matthew E. Morrow Jr. of Jacksonville was one of the principal speakers at the 39th annual meeting of the Associated Industries of Florida held the middle of October in Jacksonville. The title of Dr. Morrow's address was "Relieving Tension Under Pressure."


Drs. Charles Pinkoson and Carleton E. Van Arnam of Gainesville were among the group of Florida physicians attending the recent meeting of the American Academy of Ophthalmology held in Chicago.

Dr. Sherman B. Forbes of Tampa was in Chicago in October attending a meeting of the National Society for the Prevention of Blindness on October 10 and the annual meeting of the American Academy of Ophthalmology and Otolaryngology on October 11. He then went on to New York for two weeks' study in New York clinics.

Dr. William R. Stinger of Tallahassee has been elected president of the Florida Academy of Preventive Medicine.

Dr. G. Dekle Taylor attended the meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago on October 11-16 and served on the faculty, lecturing on the esophagus. Other Jacksonville physicians in attendance were

(Continued on page 748)



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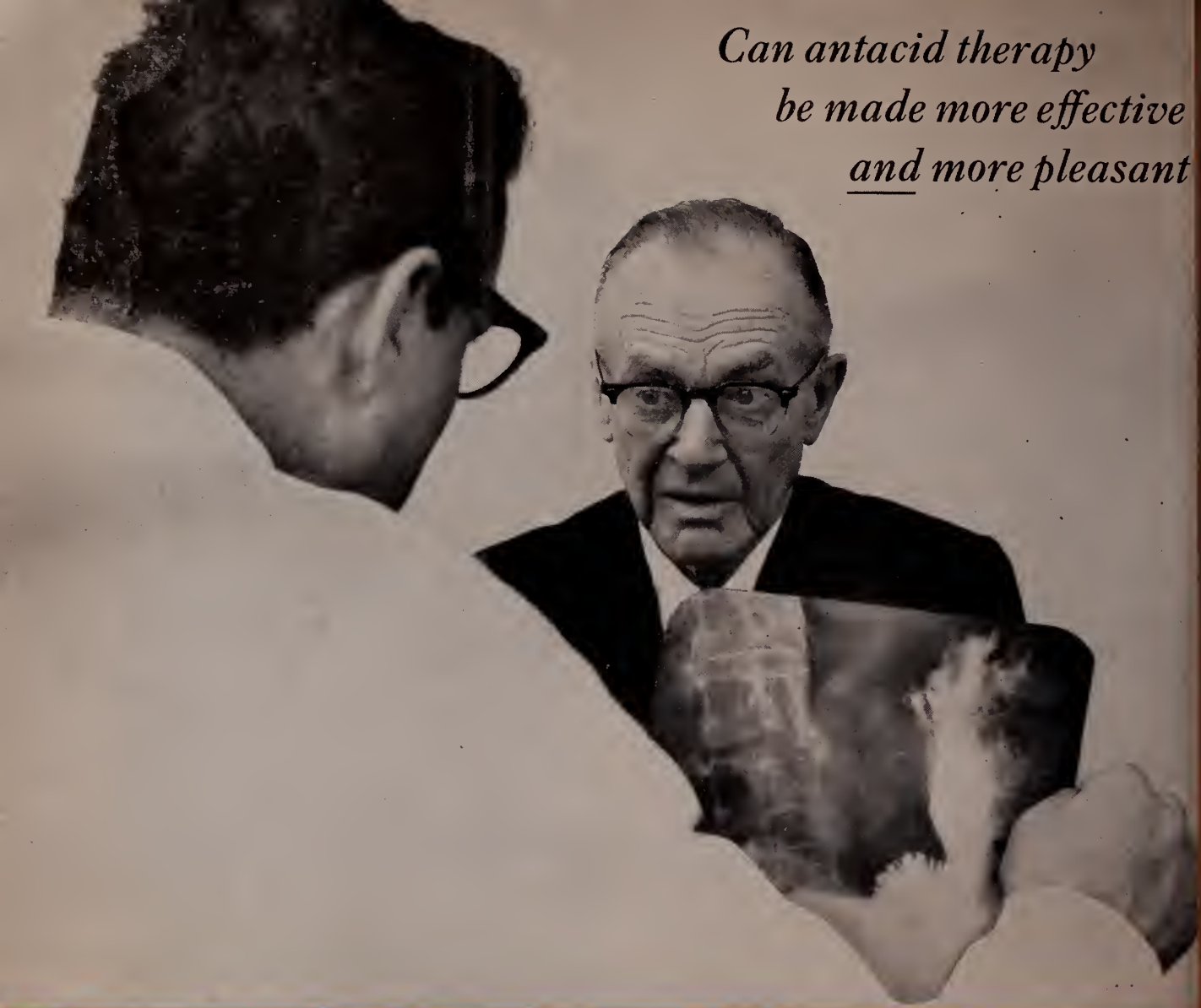
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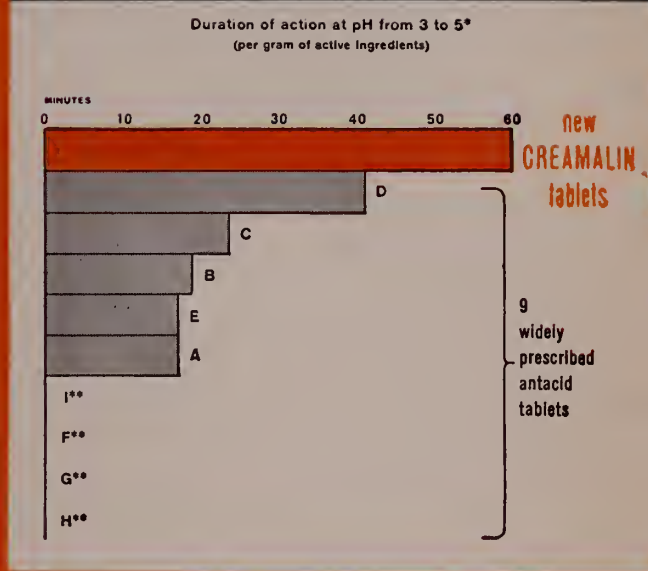
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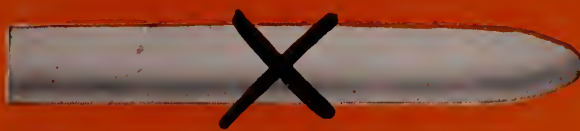


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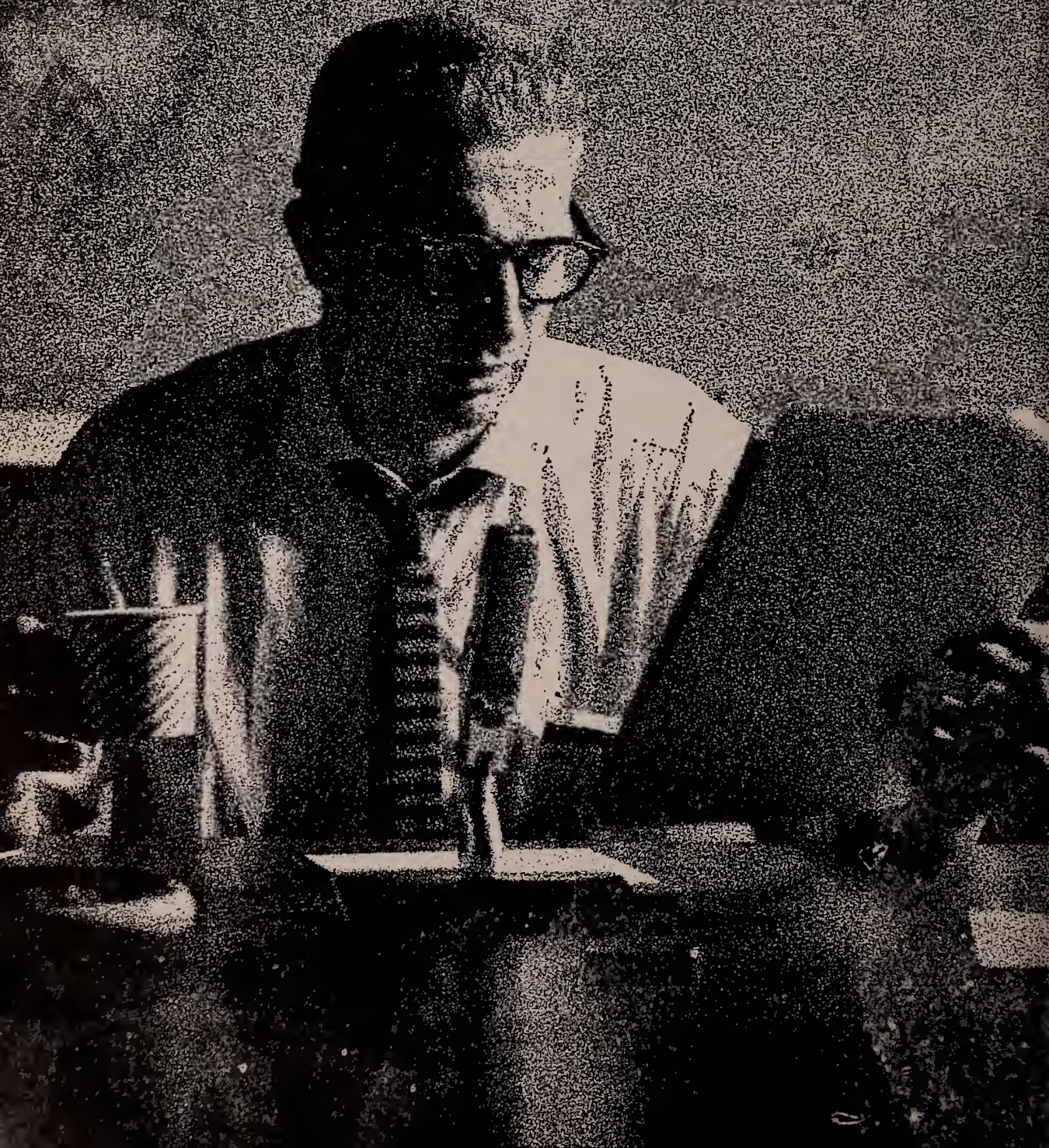


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meprobamate with PATHILON<sup>®</sup> tridihexethyl chloride Lederle

*greater flexibility in the control of tension, hypermotility  
and excessive secretion in gastrointestinal dysfunctions*

**PATHIBAMATE** combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and . . .

**PATHILON** (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of **PATHIBAMATE** have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Because of individual variation in the intensity of stimuli in gastrointestinal disorders, adequate dosage for optimum control may be expected to vary as well. The dosage strengths of **PATHIBAMATE-400** and **PATHIBAMATE-200** facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

**Supplied:** **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; **PATHILON** tridihexethyl chloride, 25 mg.

**PATHIBAMATE-200**—Each tablet (yellow, coated) contains meprobamate, 200 mg.; **PATHILON** tridihexethyl chloride, 25 mg.

**Administration and Dosage:** **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

**PATHIBAMATE-200**—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust to patient response.

**Contraindications:** glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



*(Continued from page 743)*

Drs. W. Jerome Knauer Sr., William J. Knauer Jr., and Louis A. Wilensky.

Tampa physicians attending the meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago in October included Drs. R. Renfro Duke, J. Brown Farrior, Richard T. Farrior, and Blackburn W. Lowry.

Dr. William Y. Sayad of West Palm Beach attended the October meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago.

Dr. Bernard M. Barrett of Pensacola was in Chicago in mid-October attending the meeting of the American Academy of Ophthalmology and Otolaryngology.

Dr. Eugene B. Maxwell of Tampa, First Vice President of the Florida Medical Association, officially represented the Association at the annual meeting of the Florida State Chamber of Commerce held in Tampa November 15-17. Dr. H. Phillip Hampton, also of Tampa, attended the

meeting as the representative of the Association's secretary-treasurer, Dr. Samuel M. Day.

Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, was among the group of Florida physicians attending the meeting of the Southern Medical Association in Atlanta November 16-19.

Dr. Russell B. Carson of Fort Lauderdale will be in Dallas December 1-4 to attend the Thirteenth Clinical Meeting of the American Medical Association and to appear before the Committee on Prepayment Insurance. While in Dallas, Dr. Carson will also attend a meeting of the National Blue Shield Board of which he is a member having been reelected at a recent meeting in Birmingham, Ala. Prior to leaving for Dallas, Dr. Carson was in Chicago for the annual meeting of the American Urological Association. As president of Blue Shield of Florida and a member of the National Blue Shield Board, Dr. Carson has attended three meetings in Chicago, made two trips to Michigan, attended a meeting in Birmingham and three meetings in Jacksonville since August 1.



Sanctarius on his steelyard chair in the act of weighing himself for a metabolism experiment

in obesity

bring the . . . MOOD UP  
... WEIGHT DOWN

keep BLOOD PRESSURE LEVEL  
with

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GRANUCAP®

Quadamine GRANUCAPS® provide uniform and sustained therapeutic response. No excitation or sedation. Elevates the mood, protects against nutritional deficiencies, promotes activity and depresses the urge to eat.

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Oestro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.



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a logical combination in appetite control

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meprobamate with dextro-amphetamine sulfate LEDERLE



meprobamate eases  
tensions of dieting



d-amphetamine  
depresses appetite  
and elevates mood



...without  
overstimulation  
  
...without  
insomnia  
  
...without  
barbiturate hangover

*Each coated tablet (pink) contains:*  
d-amphetamine sulfate . . . . 5 mg.  
meprobamate . . . . . 400 mg.  
*Dosage:* One tablet taken one-half  
to one hour before each meal.



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## Tetracycline-Triple Sulfa Combination (TETREX® T/S) in the Treatment of INFECTION

It is generally agreed that it is ideal to withhold antibiotic and chemotherapeutic drugs until after sensitivity tests show which antibacterial agent will be most effective. But very often, in actual practice, the physician knows that delay in starting antibacterial treatment may be detrimental to the welfare of his patient. He must then select the therapy to meet the most serious and immediate threats to the patient.

### *Why Combination Therapy?*

Certain infections do not respond as well to a single agent as to a combination. *Hemophilus influenzae* infections, which are frequent in children, are a particularly serious threat to infants and children up to about 3 or 4 years of age since they have not yet built up any appreciable immunity. Serious complications such as influenzal pneumonia, empyema, or meningitis may develop, especially in this age group. In fact, except for those periods when meningococcal meningitis is epidemic, *H. influenzae* is the most frequent cause of meningitis.<sup>1</sup> This gram-negative organism is highly susceptible both to the tetracyclines and to the sulfonamides. Even in severe infections, therapeutic failure can be virtually eliminated by giving sulfonamides plus tetracycline.<sup>1</sup> These two agents together constitute the treatment of choice, and give better results than either alone.<sup>2</sup>

Sulfonamides remain the drugs of choice for all meningococcal infections, including meningitis. They readily penetrate the blood-brain barrier and pass into the cerebrospinal fluid in good concentrations.<sup>3</sup> In treating overwhelming meningococcal infections, and complicating infections of the upper respiratory tract caused by other organisms, the addition of tetracycline to sulfas can be valuable.<sup>4</sup>

In recent years the sulfonamides have again been prescribed more and more frequently. In certain serious infections, better results can be obtained with a combination of antibiotic and sulfonamide than with either drug alone (e.g., severe pneumococcal pneumonia or pneumococcal meningitis<sup>5</sup>). Furthermore, mixed infections, to which young children are particularly susceptible, often respond only to combination therapy such as tetracycline with sulfonamides (TETREX T/S).

### *Why Triple Sulfas?*

Some sulfonamides, though therapeutically useful, frequently crystallize and cause renal dam-

age. Sulfonamide mixtures are designed to prevent this effect. It is known that different substances can coexist in solution without interfering with each other's solubility. In such a solution each component behaves as if it alone were present. Thus, a much larger total amount of sulfonamide can exist in the urine without precipitating if a mixture is administered than if the same amount of only one compound is given.

Similarly, there is less danger of hypersensitivity with mixtures. The incidence of sensitization varies directly with the dosage and is limited to the particular sulfa given. Simultaneous use of several sulfa compounds, each in partial dosage, tends to keep each drug below its own sensitization level.<sup>3</sup> As with all sulfonamides, it is advisable to check for possible blood dyscrasias, rash, or renal toxicity during extended administration.

TETREX T/S, by combining only 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine, practically eliminates serious renal damage and sensitization reactions due to sulfonamides while retaining the therapeutic efficacy of the total dose.

TETREX T/S can be administered with confidence in all severe and mixed infections due to tetracycline-sensitive and sulfonamide-sensitive organisms, including infections of the upper respiratory, urinary, and gastrointestinal tracts.

**References:** 1. Alexander, H. E.: The hemophilus group. In: Dubois, R. J.: *Bacterial and Mycotic Infections of Man*. Ed. 3, Philadelphia, J. B. Lippincott Co., 1958, p. 470ff. 2. Goodman, L. S., and Gilman, A.: *The Pharmacological Basis of Therapeutics*. Ed. 2, New York, The Macmillan Co., 1956, pp. 1322-1323. 3. Beckman, H.: *Drugs—Their Nature, Action, and Use*. Philadelphia, W. B. Saunders Co., 1958, pp. 527-528. 4. Dingle, J. H.: Meningococcal infections. In: Cecil, R. L., and Loeb, R. F.: *A Textbook of Medicine*. Ed. 9, Philadelphia, W. B. Saunders Co., 1955, p. 196ff. 5. Goodman, L. S., and Gilman, A.: *The Pharmacological Basis of Therapeutics*. Ed. 2, New York, The Macmillan Co., 1956, p. 1308.

### TETREX® T/S

Antibiotic-triple sulfa combination in a palatable, cherry-flavored syrup.

Each 5 ml. teaspoonful contains:

Tetracycline (ammonium polyphosphate buffered equivalent to tetracycline HCl activity) . . . . . 125 mg.  
Sulfadiazine . . . . . 167 mg.  
Sulfamerazine . . . . . 167 mg.  
Sulfamethazine . . . . . 167 mg.

This suspension may be stored at normal room temperature.

BRISTOL LABORATORIES INC., SYRACUSE, NEW YORK



- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMatic pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

# SOMA<sup>TM</sup>

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- More specific than salicylates
- Less drastic than steroids
- More effective than muscle relaxants

**SOMA** has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. **SOMA** is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with **SOMA** than with previously used analgesic, sedative or relaxant drugs.

**SOMA** also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

**ACTS FAST.** Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

**NOTABLY SAFE.** Toxicity of **SOMA** is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

**EASY TO USE.** Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

**SUPPLIED:** Bottles of 50 white coated 350 mg. tablets.

*Literature and samples on request.*



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NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY

tranquilization

anti-emetic<sup>®</sup>

greater specificity  
tranquillizing action  
divorced from such  
"diffuse" effects as  
anti-emetic action  
—explains why

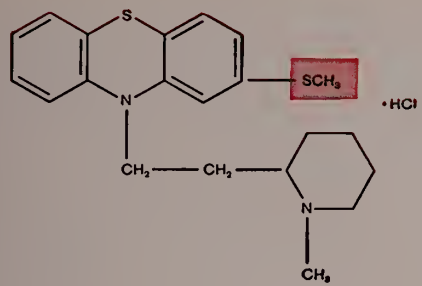
**Mellaril<sup>®</sup>**

THIORIDAZINE HCl

is virtually free of such toxic effects as • jaundice • Parkinsonism • blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>\*</sup>

a new advance in tranquilization!  
greater specificity of tranquilizing action results in fewer side effects



*The presence of a thiomethyl radical (S-CH<sub>3</sub>) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

**MELLARIL**

PSYCHIC RELAXATION

DAMPENING OF SYMPATHETIC AND PARASYMPATHETIC NERVOUS SYSTEM

Minimal suppression of vomiting

Little effect on blood pressure and temperature regulation

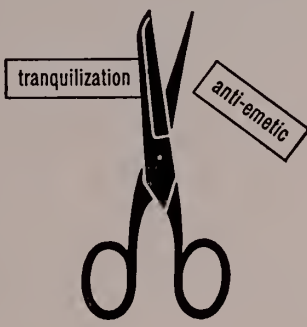
Psychic relaxation

Dampening of sympathetic and parasympathetic nervous system

Strong suppression of vomiting

Dampening of blood pressure and temperature regulation

**other phenothiazine-type tranquilizers**



- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
<b>ADULTS:</b> Mental and Emotional Disturbances: MILD —where anxiety, apprehension and tension are present MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc. SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.: <div>Ambulatory Hospitalized</div>	10 mg. t.i.d. 25 mg. t.i.d.  100 mg. t.i.d. 100 mg. t.i.d.	20-60 mg. 50-200 mg.  200-400 mg. 200-800 mg.
<b>CHILDREN:</b> BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

\*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959





## for therapy of overweight patients

- d-amphetamine  
*depresses appetite and elevates mood*
- meprobamate  
*eases tensions of dieting*  
(yet without overstimulation, insomnia  
or barbiturate hangover)

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is a logical combination in appetite control

Each coated tablet (pink) contains: meprobamate, 400 mg.; d amphetamine sulfate, 5 mg.  
Dosage: One tablet one-half to one hour before each meal.



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**WANTED:** Radiologist seeking associate—congenial Orlando area. Limited volume, currently diagnosis only. Some hospital work. Florida license required. Write 69-322, P.O. Box 2411, Jacksonville, Fla.

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**NEEDED:** Associate for general practice of medicine for north Florida area. Florida license required. Write 69-337, P. O. Box 2411, Jacksonville, Fla.

**NEEDED IMMEDIATELY:** A white physician, by a long established private sanitarium, treating nervous and mental diseases, and addiction problems. Also opportunity for psychosomatic medicine. Psychiatric experience preferred, not absolutely necessary. Semi-retired or retired physician not over 66 would be considered. Good salary; work not heavy. Write 69-339, P. O. Box 2411, Jacksonville, Fla.

**NEED AN ASSOCIATE?** 34 year old family man now in good Northern solo practice desires an association in a progressive location in Florida. Member AAGP and local medical society. Florida license. Five years out of topnotch internship. Write 69-346, P. O. Box 2411, Jacksonville, Fla.

**LOCATION WANTED:** Ophthalmologist, Diplomate, extensive experience. Florida license. Accessibility to water more a factor than size of community or income. Write 69-349, P.O. Box 2411, Jacksonville, Fla.

**WANTED:** Two young associates for General Practice. One with training in anesthesia, the other in surgery, to be associated with General Practitioner with 28 bed hospital. Florida license required. Will guarantee suitable associates \$1000 per month with partnership later. Write 69-352, P. O. Box 2411, Jacksonville, Fla.

**SITUATION WANTED:** Otolaryngologist, age 35, certified; desires associateship in Florida. University trained. Florida license. Write 69-353, P. O. Box 2411, Jacksonville, Fla.

**WANTED:** Young General Practitioner for associateship with established physician in greater Jacksonville area. General and industrial practice. Write 69-350, P. O. Box 2411, Jacksonville, Fla.

**FOR SALE:** Used medical equipment in excellent condition: Microtherm diathermy; medi-sanar ultra sound machine, portable; Mattern X-Ray machine; Office music system. Write 69-296, P. O. Box 2411, Jacksonville, Fla.

**FOR RENT:** Desirable medical office in St. Petersburg. Ground floor. Excellent location. Ample parking space. Reasonable rent. Write 2713 First Ave., N., St. Petersburg.

**WANTED:** Orthopedic surgeon for location in northern Florida. Board member or qualified desired. Well trained, not completely qualified person would be considered. Write 69-344, P.O. Box 2411, Jacksonville, Fla.

**NEW YORK GENERAL PRACTITIONER:** Retiring very shortly (have surgical and obstetrical ratings) desires full or part time institutional position in Old Age Home, Rest Home, Sanitarium, etc. Salary of no importance, desires to be active. Please contact 69-354, P.O. Box 2411, Jacksonville, Fla.

**WANTED:** General physician, specialist and internist to associate with well-established medical group in fast growing, high class residential area of St. Petersburg-Clearwater. Ground floor in new air-conditioned medical building. Large reception room, furnished. Excellent hospitals. Write Midway Medical Center, Box 8192, Madeira Beach, Fla.

**ATTENTION PATHOLOGISTS—FOR SALE:** Autotechnicon, Spencer microtome, water bath and dryer in excellent condition. Write 69-355, P. O. Box 2411, Jacksonville, Fla.

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### COMPONENT SOCIETY NOTES

#### Brevard

Dr. Chester M. Thompson of Orlando was featured scientific speaker on the program for the September meeting of the Brevard County Medical Society held at Indialantic. The title of Dr. Thompson's address was "The Clinical Uses of the Electroencephalogram."

Dr. J. Cornall Howarth of Orlando was principal speaker at the October meeting held at Cocoa Beach. Dr. Howarth discussed diagnostic methods in use at present in neurosurgery.

#### Dade

Senator George A. Smathers discussed "The Smathers-Simpson-Keogh Bill — It's Future in Congress" at the November meeting of the Dade County Medical Association.

#### Duval

Dr. Emery C. Miller Jr., Instructor in Internal Medicine and Physiology and Pharmacology at Bowman Gray School of Medicine, was

If she needs nutritional support . . . she deserves

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Vitamin-Mineral Supplement Lederle

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Pearl River, New York



principle scientific speaker at the November meeting of the Duval County Medical Society. The title of Dr. Miller's address was "Pharmacologic Principles in the Use of Corticoids."

#### Hillsborough

Dr. David P. Baumann, director of Tampa General Hospital, was principal speaker for the October meeting of the Hillsborough County Medical Association. The title of Dr. Baumann's address was "Diagnostic Aids in the Management of Congenital and Acquired Heart Disease."

Dr. Lawrence Kahana of Tampa discussed "Recent Advances in Endocrinology" at the November meeting of the Association held at the Floridan Hotel.

#### Lake

Mr. W. J. Stansell and Mr. Whalen M. Strobhar from the Physicians' Relations Department of Blue Shield discussed the functions of Blue Shield, particularly the new Type A Contract, at the September meeting of the Lake County Medical Society held at the Howey Country Club at Howey-in-the-Hills.

Mr. C. Welborn Daniel, state representative, was principal speaker at the Society's October

meeting held at the Elks Club in Leesburg. Mr. Daniel discussed reapportionment.

#### Lee-Hendry

Dr. George D. Hopkins of Fort Myers has been elected president of the Lee-Hendry County Medical Society. Chosen to serve with Dr. Hopkins are Dr. Wilson A. Rumberger as vice president and Dr. Leland K. Glenn secretary-treasurer. Both are from Ft. Myers. The new officers are to be installed at the Society's December meeting.

#### Marion

The Marion County Medical Society has paid 100 per cent of its state dues for 1959.

#### Monroe

The Monroe County Medical Society has paid 100 per cent of its state dues for 1959.

#### Orange

Mr. Farris Bryant of Ocala, attorney and former Speaker of the House of Representatives, was principal speaker for the September meeting of the Orange County Medical Society. The title of Mr. Bryant's address was "The Doctor's Responsibility in Growing Florida."

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#### the advantages of oil suspension

rapid even coverage on eye, lids, fornices . . .  
resists dilution by lacrimation . . . maintains  
effective antibiotic concentrations

#### the effectiveness of ACHROMYCIN

rapid suppression of common cocci and bacilli and of susceptible viruses—whether the primary infection or a complication of irritation, trauma, or inflammatory disease . . . fast resolution of swelling, erythema, and lesions . . . excellently tolerated

#### in the unique dropper-bottle

precise measurement of dose . . . clean . . . minimizes contamination . . . 4 cc. plastic squeeze dropper-bottle; 10 mg. (1%) ACHROMYCIN Tetracycline HCl per cc. sesame oil suspension



# ACHROMYCIN<sup>®</sup>

Tetracycline Lederle

## OPHTHALMIC OIL SUSPENSION 1%



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Each tablet contains: Iron (Ferrous Sulfate Exsiccated 194 mg.), 58 mg.; Dioctyl Sodium Sulfosuccinate, 100 mg.; Vitamin A, 6000 U.S.P. Units; Vitamin D, 400 U.S.P. Units; Vitamin B<sub>1</sub> (Thiamine Mononitrate), 5 mg.; Vitamin B<sub>2</sub> (Riboflavin), 5 mg.; Vitamin B<sub>6</sub> (Pyridoxine HCl), 2 mg.; Vitamin B<sub>12</sub> Activity (Cobalamin Conc.), 2 mcg.; Vitamin C, 100 mg.; Folic Acid, 0.25 mg.; Niacinamide, 20 mg.; Calcium Pantothenate, 5 mg.; Calcium (Calcium Carbonate), 150 mg.; (Phosphorus free formula).

**strength and vitality...**

**freedom from constipation**



# \*TERMINATAL<sup>®</sup> (Tablets, Benton)

prenatal dietary supplement  
high iron content in a potent  
nutritional formula  
counteracts prenatal constipation  
sensibly packaged in re-usable  
nursing unit  
one-a-day dosage convenience

Addition of dioctyl sodium sulfosuccinate to offset constipation of pregnancy by fecal softening makes TERMINATAL a *unique* high-potency dietary supplement for use to term.

*Supplied:* 100 TERMINATAL capsule-shaped tablets are packaged in a useful nursing bottle with nipple, ready for the infant's first formula.



**BENTON Laboratories** Hatboro, Pennsylvania  
Division of Air-Shields, Inc.



*Striking relief*  
**from LOW BACK PAIN**  
*and* **DYSMENORRHEA**  
THE FIRST TRUE "TRANQUILAXANT"  
*Trancopal*





# Here is what you can expect when you prescribe

## Case Profile\*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.

for dysmenorrhea  
*and premenstrual tension*



# *Trancopal*<sup>®</sup>

THE FIRST TRUE "TRANQUILAXANT"

for low back pain



## Case Profile\*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

*\*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.

# THE FIRST TRUE "TRANQUILAXANT" *Trancopal*

potent **MUSCLE RELAXANT**

effective **TRANQUILIZER**

- In musculoskeletal disorders, effective in 91 per cent of patients.<sup>1</sup>
- In anxiety and tension states, effective in 89 per cent of patients.<sup>1</sup>
  - Low incidence of side effects (2.3 per cent of patients). Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
  - No gastric irritation. Can be taken before meals.
  - No clouding of consciousness, no euphoria or depression.

## Indications 1-6

### Musculoskeletal:

Low back pain  
(lumbago, etc.)  
Neck pain (torticollis)  
Bursitis  
Rheumatoid arthritis  
Osteoarthritis  
Disc syndrome

Fibrositis  
Ankle sprain, tennis  
elbow  
Myositis  
Postoperative muscle  
spasm

### Psychogenic:

Anxiety and tension  
states  
Dysmenorrhea  
Premenstrual tension  
Asthma  
Angina pectoris  
Alcoholism

## Now available in two strengths:

NEW  
STRENGTH



Trancopal Caplets®,  
100 mg. (peach colored, scored), bottles of 100.



Trancopal Caplets,  
200 mg. (green colored, scored), bottles of 100.

*Dosage:* Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

*Winthrop* LABORATORIES  
New York 18, N. Y.

*References:* 1. Collective Study, Department of Medical Research, Winthrop Laboratories. 2. Lichtman, A. L.: New developments in muscle relaxant therapy, *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Lichtman, A. L.: Relief of muscle spasm with a new central muscle relaxant, chlormezanone (Trancopal), Scientific Exhibit, Meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 4. Ganz, S. E.: Clinical evaluation of a new muscle relaxant (chlormethazanone), *J. Indiana M. A.* 52:1134, July, 1959. 5. Mullin, W. G., and Epifano, Leonard: Chlormezanone, a tranquilizing agent with potent skeletal muscle relaxant properties, *Am. Pract. Digest Treat.* 10:1743, Oct., 1959. 6. Shanaphy, J. F.: Chlormezanone (Trancopal) in the treatment of dysmenorrhea; a preliminary report, *Current Therap. Res.* 1:59, Oct., 1959.

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off. 1408M Printed in U.S.A.





Dr. John J. McAndrew of Orlando was principal scientific speaker at the Society's October meeting. His topic was "Griseofulvin and the Skin Fungal Problem."

#### Pinellas

Dr. Jere W. Annis of Lakeland, Immediate Past President of the Florida Medical Association, was principal speaker at the September meeting of the Pinellas County Medical Society. The title of Dr. Annis' address was "The Doctor's Debts . . . to Society."

#### Suwannee-Hamilton-Lafayette

The Suwannee-Hamilton-Lafayette County Medical Society has paid 100 per cent of its state dues for 1959.

#### Volusia

Dr. George T. Harrell of Gainesville, Dean of the College of Medicine, University of Florida, was principal speaker at the November meeting of the Volusia County Medical Society held at Daytona Beach. Dr. Harrell's topic was "Referral and Admitting of Patients to the University Hospital."

### NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bencker, Fred W., Lake Worth  
Brinson, John B. Jr., Madison  
Brown, Trave L. Jr., Holmes Beach  
Brunoehler, Carl J., Winter Park  
Daniels, Virgil C. Jr., St. Petersburg  
Dean, Harry B., Miami  
Fein, Clayton L., Miami Beach  
Galloway, Dolph V., Daytona Beach  
Gervais, Robert H., Bradenton  
Glasson, Lancelot G. G., South Miami  
Johnson, Curtis C., Delray Beach  
Lesser, Leonard I., Miami  
Mahoney, John R., Fort Lauderdale  
Makol, James G., North Miami Beach  
Moran, James D., Bradenton  
Newton, Lyle A., St. Petersburg  
O'Dell, John C. Jr., Bradenton  
Quimby, C. Sumner, Bradenton

If he needs nutritional support . . .



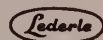
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Reid, Harry G. Jr., Miami  
Robinson, John R., West Palm Beach  
Stough, Warren V., Fort Lauderdale  
Taubel, David E., Ft. Lauderdale  
Tindall, Robert L., Coral Gables  
Toporoff, George S., Lake Worth  
Travis, Burton L., Miami Springs

**BIRTHS AND DEATHS**

**Births**

Dr. and Mrs. James R. Trimble of Jacksonville announce the birth of a son, Thomas Bell, on July 19, 1959.  
Dr. and Mrs. Emmet F. Ferguson Jr. of Jacksonville announce the birth of a daughter, Fran Ellen, on June 23, 1959.  
Dr. and Mrs. Apostolos A. Kartsonis of Jacksonville announce the birth of a daughter, Arlene Pauls, on July 16, 1959.  
Mr. and Mrs. Dallas J. Calhoun (Dr. Lois E. Friedl) of Jacksonville announce the birth of a son, Brian Thomas, on July 26, 1959.  
Dr. and Mrs. Paul L. Mahoney Jr. of Jacksonville announce the birth of a daughter, Lynn Elizabeth, on August 1, 1959.

**Deaths — Other Doctors**

Canright, Harry Lee, St. Cloud.....May 28, 1959  
Gallagher, James S., St. Petersburg.....June 4, 1959  
Glasener, Charles F., Bradenton.....May 28, 1959  
Griffin, Silas, St. Petersburg.....May 25, 1959  
Hall, Francis M., Port St. Joe.....April 6, 1959  
Linsin, Ivan M., St. Petersburg.....May 29, 1959

**OBITUARIES**

**Paul Kass**

Dr. Paul Kass of North Miami died on May 26, 1959. He was 56 years of age.  
Born in Houston, Texas on June 10, 1902. Dr. Kass received his academic schooling at Rice Institute in his home city and his medical training at the University of Virginia School of Medicine. He was awarded the degree of Doctor of Medicine by that institution in 1928. He served a two year internship at Lenox Hill Hospital in New York City and then engaged in the general practice of medicine in Richmond Hill, New York City, for 22 years. During that period he was an active member of Queens County Medical Society and the New York State Medical Association. In 1956, he located in North Miami and established his practice there.

Dr. Kass was a member of the Dade County Medical Association and since 1957 had held membership in the Florida Medical Association.

*(Continued on page 768)*

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Ammonium chloride	75.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
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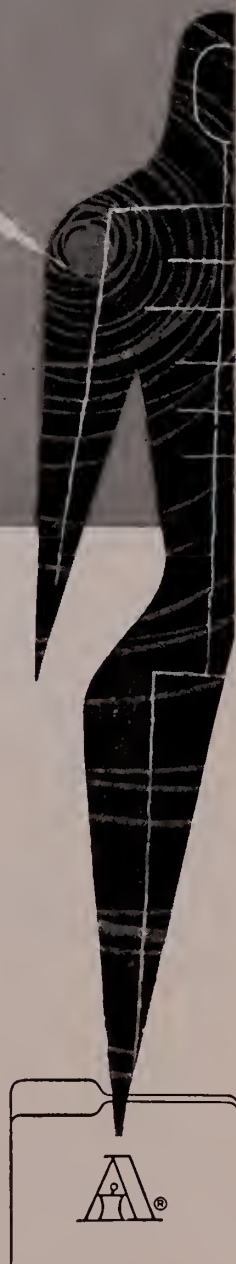
Each package of Depinar consists of a multiple dose vial, containing cyanocobalamin zinc tannate (lyophilized) equivalent to 2500 mcg. vitamin B<sub>12</sub>. The vial of diluent contains 5 cc. Sodium Chloride Solution for Injection. When reconstituted, each ml. of Depinar contains 500 mcg. vitamin B<sub>12</sub>.

\*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition  
7:311-317 (May-June) 1959.

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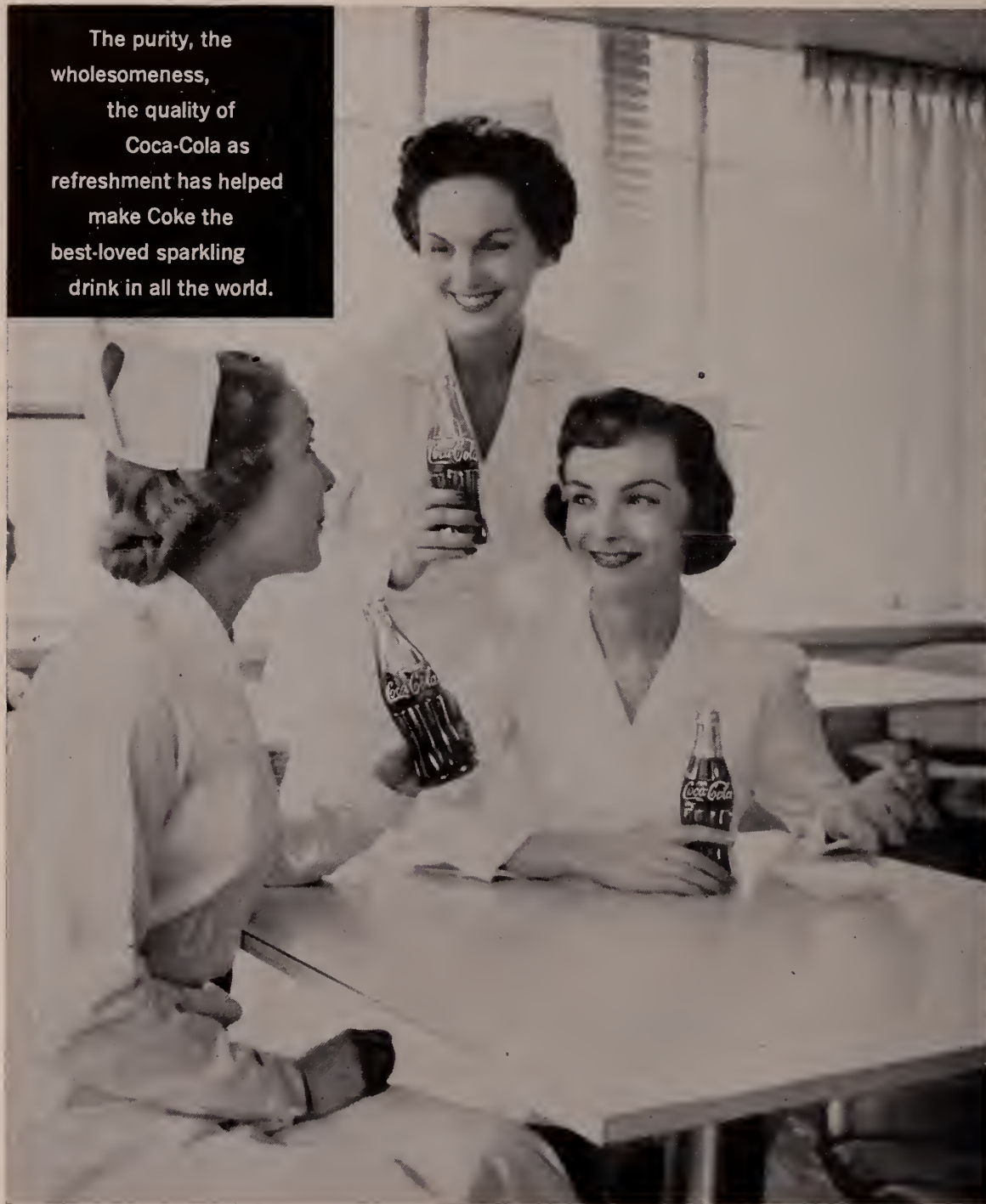
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Phenylazodiaminopyridine HCl-Sulfamethoxypyridazine **Lederle**



## COMPLEMENT FOR KYNEX

**Adds fast-acting analgesia** of phenylazodiaminopyridine HCl. Relieves burning, urgency and pain-spasm. Eases voiding and retention of infected urine.

...to **unexcelled sulfa control** of KYNEX. Lower dosage of just ½ Gm. daily...prolonged action without hazard of crystalluria...reduced toxic potential...not surpassed by any other sulfa drug, singly or in combination. Dosage: Two tablets q.i.d. first day; one tablet q.i.d. thereafter. Each tablet contains: 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

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**RELA<sup>TM</sup> EASES STRAINS  
SPRAINS & LOW  
BACK PAINS...! X**

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**RELA**—a new myogestic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

**RELA**—though a single drug—is a true myogestic and works rapidly to achieve three desired effects...

**Rela relaxes acute muscle spasm**

Relief of muscle spasm (96% excellent to good effectiveness)<sup>1</sup>

**Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions**

"Relief from pain was usually rapid and sometimes dramatic"<sup>1</sup>

**Rela, through relaxation and analgesia, assures daytime ease and nighttime rest**

"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."<sup>1</sup>

**indications:** RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

**safety:** Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

**dosage:** The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

**supply:** RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.

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*A few suggestions to help the diet fit your patient's  
personal preferences and way of life*

*—and a glass  
of beer, with  
your consent,  
for a morale-  
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# The Diabetic Diet

A measured diet is vital. Portions should be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect. A food exchange list provides variations in diet. Insulin demands food with the urgency and regularity of an alarm clock.

If dinner is late, suggest a light snack at the usual mealtime with corresponding caloric reduction in the delayed meal. Hard candies do

well as a precaution against insulin reaction. Plan low calorie wafers when others nibble canapés or chocolates. Above all, give your patient a variety of his food preferences.

And with a glass of beer\*—at your discretion—your patient will find his diet interesting and ample without straying from instructions.

\*Carbohydrate 9.4 Gm; Protein 0.8 Gm; Calories 104/8 oz.  
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If you'd like reprints of this and 11 other dietary suggestions, please write United States Brewers Foundation, 535 Fifth Avenue, New York 17, N. Y.



(Continued from page 760)

He was also throughout the years a member of the American Medical Association.

Surviving are the widow, Mrs. Myrtle Kass, and his mother, Mrs. Sophie Kass, of North Miami.

### Byrne Evans Taylor

Dr. Byrne Evans Taylor of Orlando met instant death in a racing boat accident at Daytona Beach on June 14, 1959. He was 53 years of age.

Born at Wills Point, Texas, on Feb. 17, 1906, Dr. Taylor received his early schooling in his native state and his premedical training at Union College, Lincoln, Neb. He obtained his medical education at the College of Medical Evangelists in Los Angeles and was awarded the degree of Doctor of Medicine by that institution in 1932. He then engaged in postgraduate training, specializing in ophthalmology and otolaryngology.

Dr. Taylor entered the private practice of medicine in Orlando in 1934 and continued to practice his specialty there for a quarter of a

century. During World War II he served from 1942 to 1945 as a lieutenant commander in the United States Navy. He then resumed his practice in Orlando and in recent years limited it to ophthalmology. Locally, he was on the active staff of the Florida Sanitarium and Hospital and had served as president of the staff and also as chief of the surgical service. He was a member of the Kress Memorial Seventh Day Adventists Church in Winter Park.

Since 1934 Dr. Taylor had held membership in the Orange County Medical Society and the Florida Medical Association. He was also a member of the American Medical Association, Southern Medical Association, Florida Society of Ophthalmology and Otolaryngology, Flying Physicians Association, College of Medical Evangelists Alumni Association and Florida Chapter of the College of Medical Evangelists Alumni Association.

Dr. Taylor is survived by his widow, Mrs. Dorothy Taylor, a son, George Taylor, and a daughter, Gayle Taylor, all of Orlando; his father, C. U. Taylor, of Winter Park; two sisters, Mrs.

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Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can be used separately as a wall cabinet and the lower section as a treatment stand. This option allows a greater variety of room arrangement according to personal preference and requirements.

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Veratrite now contains cryptenamine which acts centrally to produce a gradual fall in blood pressure, yet improves circulation to vital organs, relieves dizziness and headache, and imparts a distinct sense of well-being. Furthermore, Veratrite achieves its effects with unusual safety and without annoying side effects.

Each Veratrite tabule contains: Cryptenamine (tanates), 40 C.S.R.\* Units; Sodium nitrite, 1 gr.; Phenobarbital, ¼ gr. Dosage: 1-2 tabules t.i.d., preferably 2 hours after meals.

\*Carotid Sinus Reflex

*Neisler*

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Stanley, of Atlanta, Ga., and Mrs. Areta Martin, of Orlando; and a nephew, Dr. Ulric Martin.

### Americo James Ferlita

Dr. Americo James Ferlita of Tampa died in a local hospital on July 2, 1959. He was 51 years of age.

A native Tampan, Dr. Ferlita was graduated from Sacred Heart High School, now known as Jesuit High School, and completed his premedical training at the University of Florida. He then attended the Stritch School of Medicine of Loyola University in Chicago, where he was awarded the degree of Doctor of Medicine in 1934. Later, he engaged in postgraduate studies at the University of North Carolina School of Medicine.

Upon his return to Tampa after graduation, Dr. Ferlita entered the private practice of medicine as a general practitioner and continued to practice there for a quarter of a century. In addition, he served for more than 21 years as City Physician, a position he held at the time of his death. A civic leader as well as a faithful public servant, he was a member and past exalted ruler of BPOE No. 708, and a member of the Italian

Club, the Ybor City Optimist Club, the Davis Island Yacht Club and numerous other civic and private organizations.

Dr. Ferlita was a member of the Hillsborough County Medical Association, the Florida Medical Association and the American Medical Association. He also held membership in the American Academy of General Practice, and his fraternity was Phi Beta Phi.

Surviving are the widow, Mrs. Nina Tagliarini Ferlita, and three sons, Ross A. Ferlita, Frank S. Ferlita and Donnie N. Ferlita, all of Tampa; two sisters, Mrs. Teresa Diecidue, of San Clemente, Calif., and Mrs. Joseph Minardi, of Tampa; and three brothers, Angelo Ferlita, Salvatore Ferlita and Tony Ferlita, all of Tampa.

### Duncan McInnis Draughn

Dr. Duncan McInnis Draughn of Moore Haven died on July 22, 1959, in Arlington, Va., where he had gone for treatment to be near his daughter, Mrs. H. F. Dietz, who resides there. He was 72 years of age. Interment was in the Columbia Gardens Cemetery in Arlington.

Born in Hattiesburg, Miss., on April 21, 1887, Dr. Draughn attended public schools there and later was graduated from Castle Heights Military Academy in Tennessee. He received his academic degree from Vanderbilt University in Nashville, Tenn., and then studied medicine at the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore, where he was awarded the degree of Doctor of Medicine in 1913. He interned at New York Hospital in New York City. His social fraternity was Kappa Alpha and his medical fraternity Chi Zeta Chi.

Shortly after he began the general practice of medicine in Miami, he entered the Medical Corps of the United States Army, serving in World War I. He was attached to the Eighty-Second Division and served two years overseas in France. When he returned to civilian life, he chose to settle in Moore Haven, then a thriving community three times its present size. The only physician for miles around, he served the community faithfully and well for more than four decades. He traveled by mule back and by row boat as well as by car and went forward on foot when these modes of transportation were inadequate. He took great pride in the babies he had delivered through the years, and in 1952 on the oc-

(Continued on page 776)

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Each coated tablet (pink) contains: meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.  
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### ALTAFUR in antibiotic-resistant staphylococcal infections

ALTAFUR proved superior to any other single agent against staphylococcal infections encountered in the pediatric section of a general hospital. Introduced during an epidemic of severe staphylococcal pneumonia and bronchiolitis in younger children, ALTAFUR was employed in treating a total of 59 infants or juvenile patients, most of whom had upper or lower respiratory tract involvement. Almost all had been given antibiotics without effect; 34 were judged severely or critically ill. Cures were obtained in 54 of these patients after a 3 to 10 day course of ALTAFUR. There was only one failure (results were inconclusive in the remaining four cases). Mixed infections with *Pneumococcus* or *Streptococcus* sp. also responded readily.

ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal in these patients, being limited to gastric intolerance in a few cases, usually controllable by giving the drug with or after meals. Laboratory studies performed before and after ALTAFUR treatment revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

In vitro, staphylococci isolated in this series proved uniformly susceptible to ALTAFUR, whereas many strains were resistant to a variety of antibiotics. With ALTAFUR as with all nitrofurans, the lack of development of significant bacterial resistance is considered a major advantage over other antimicrobials.

Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academics of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

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in the antibacterial firmament

**ALTAFUR** T. M.  
brand of furaltadone

the first nitrofuran effective orally  
in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
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Tablets of 50 mg. (pediatric) and 250 mg. (adult)  
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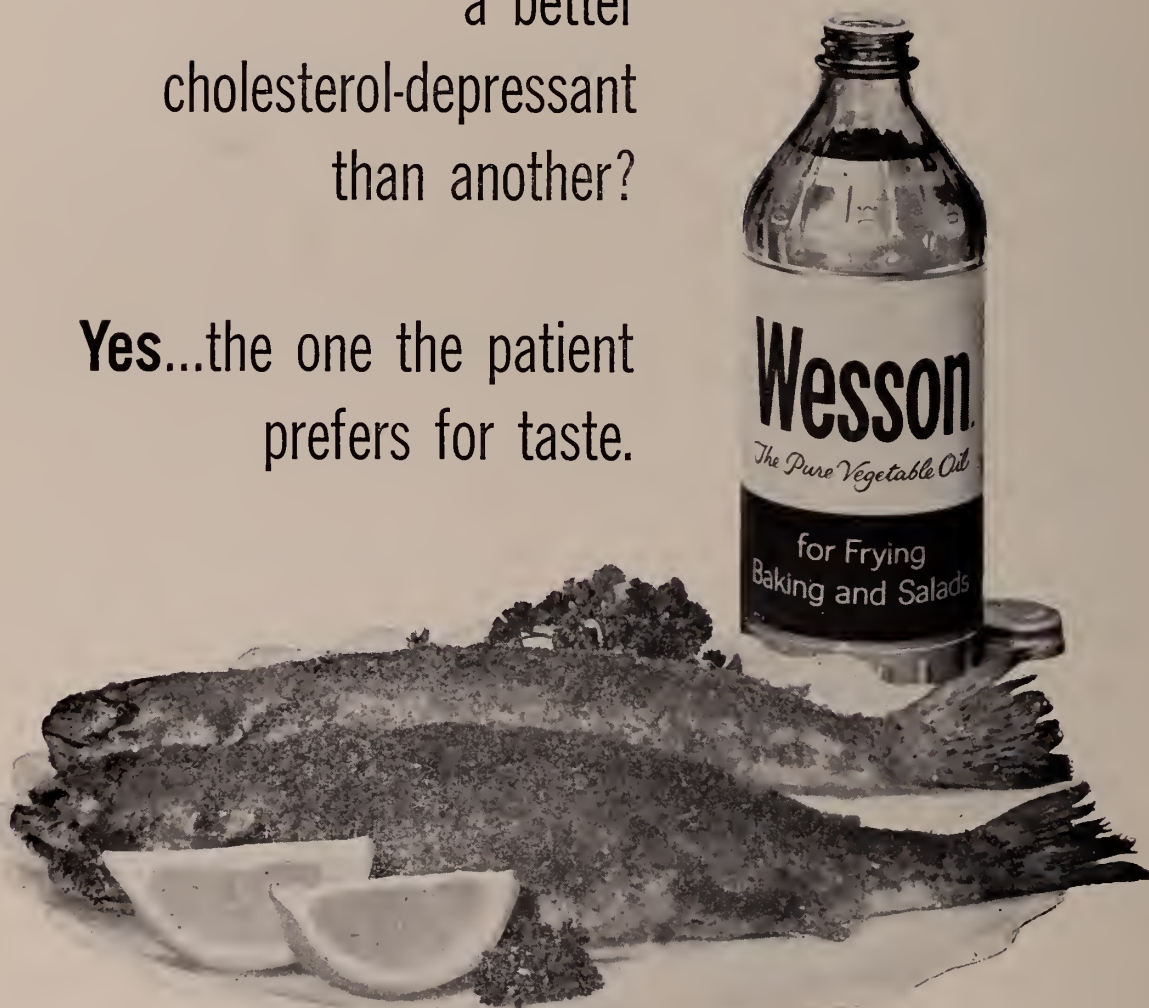
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(Continued from page 770)

casation of his sixty-fifth birthday, several hundred of his patients, "his babies," and his friends gathered to do him honor. At that time a leading metropolitan newspaper conferred upon him his most cherished title, "Doctor Moore Haven." He was a member of the American Legion, the Masonic Lodge and the Presbyterian Church.

Dr. Draughn was a member of the DeSoto-Hardee-Glades County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association and other medical organizations.

Surviving are the widow, the former Lora Haney of Hattiesburg; two daughters, Mrs. Dietz and Miss Mary Ann Draughn; and a sister, Mrs. Robert Burkes, of New Orleans.

### Stewart Lee Jeffrey

Dr. Stewart Lee Jeffrey of Miami died at his home in Coconut Grove on July 21, 1959. He was 77 years of age.

Upon completing his premedical education at Harvard University, Dr. Jeffrey received his medical training at Columbia University College of Physicians and Surgeons. He was awarded the

degree of Doctor of Medicine by that institution in 1904 and then engaged in postgraduate study in Vienna, Austria. Upon his return to this country, he entered the private practice of medicine in New York City, where he was active in the Fourth Separate Company, New York State National Guard, Medical Corps.

In 1915, Dr. Jeffrey came to Florida to reside and engaged in the practice of internal medicine in Miami. During World War I he served for three years as an officer of the United States Navy Reserve Corps and then resumed his practice in Coconut Grove. Locally, he was on the staff of Mercy Hospital and of Jackson Memorial Hospital. He was a member of the Military Order of the World Wars and held membership in the Biscayne Bay Yacht Club. He was affiliated with St. Stephen's Episcopal Church, where he was a vestryman.

A practitioner of medicine for 53 years, Dr. Jeffrey spent more than four decades of his professional career in Miami. He was a member of the Dade County Medical Association and the Florida Medical Association and also held membership in the American Medical Association and the organizations of his specialty.

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
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Dr. Jeffrey was married in August 1920 to Miss Ruth Batchelder, who survives him.

### Leonard George Rowntree

Dr. Leonard George Rowntree of Miami Beach died on June 2, 1959, after a lingering illness. He was 76 years of age.

Born in London, Ontario, on April 10, 1883, Dr. Rowntree had received the degree of Doctor of Medicine from Western Ontario Medical School and had served an internship in Canada before coming to the United States in 1906. He embarked upon a career of academic medicine at the Johns Hopkins University School of Medicine and was soon invited into the clinical field there as Associate Professor of Medicine. In 1916, he was appointed Professor of Medicine at the University of Minnesota. Enlisting in the Army Medical Corps in 1918, he became one of two men primarily responsible for establishing the first Military Department of Aviation Medicine and he held the post of Executive Officer of the Air Service (medical) in the American Expeditionary Force. In 1920, he received the appointment of Chief of Medicine in the Mayo Foundation, Professor of Medicine in the Graduate School, Director of Clinical Investigation, and Senior Medical Consultant in the Mayo Clinic. Twelve years later, he accepted the position of Director of the Philadelphia Institute for Medical Research. In 1940, by Presidential appointment he was made Chief of Medicine at National Headquarters of Selective Service. After World War II he served for more than a decade as Chief Medical Advisor and Chairman of the Medical Advisory Board of the American Legion.

Dr. Rowntree became a resident of Miami Beach in 1945 and was the first internist in the Miami area to limit his practice to consultation. He was Chief Consultant at the Veterans' Administration Hospital in Coral Gables. As a co-founder of the University of Miami School of Medicine, he secured from the Veterans' Administration the loan of a vacant building which has housed the medical school from its early beginning.

Among the many honors bestowed upon this distinguished physician, himself a semi-invalid throughout his brilliant career, were the Medal of Merit in 1945, the Distinguished Service Cita-

(Continued on page 784)

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(1) Beck, J. W.; Saavedra, D.; Antell, G. J., & Tejeiro, B.: *Am. J. Trop. Med.* 8:349, 1959.

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*References:* 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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1. Goodman, L.S. and Gilman, A.: The Pharmacologic Basis of Therapeutics, MacMillan, 1955.





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2. Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)  
3. Scheinberg et al: Surgery 24:972, 1948 (Dec.).

(Continued from page 778)

tion in 1954, the Strittmater Award of Philadelphia for 1938, and a citation in 1944 by the University of the State of New York. An outstanding contributor to medical advancement, he was the author of a multitude of papers on medical subjects, and in 1958 his book entitled "Amid Masters of Twentieth Century Medicine" was published.

Dr. Rowntree was licensed to practice medicine in Florida in January 1946. For 12 years he held membership in the Dade County Medical Association and the Florida Medical Association.

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## BOOKS RECEIVED

**Gynecologic Radiography.** By Jean Dalsace, M.D., and J. Garcia-Caldéron, M.D. With a Chapter on Radiography of the Breast by Charles-M. Gros, M.D., and Robert Sigrist, M.D., Pp. 188. Illus. 360. Price, \$8.00. New York, Paul B. Hoeber, Inc., 1959.

Translation into English of this French atlas on hysterosalpingography is both timely and welcome. Despite the passage of more than four decades since the method was devised independently in this country and in France, this is the first atlas of its kind to be made available to American readers. The exceptionally fine collection of gynecologic radiographs presented will prove of particular interest to all gynecologists, obstetricians and radiologists. The technics of hystero-radiography and hysterosalpingography are clearly explained. In addition, the concise text and more than 300 illustrations demonstrate the findings in a wide variety of clinical problems, including uterine flexion and version, fibroids and polyps, cancer of the cervix and corpus uteri, tubal obstruction, ovarian cysts, incomplete abortion, peritubal adhesions, et cetera. The final section on radiography of the breast reveals the potential value of a new tool for diagnosis of infections, dysplasia, and benign and malignant tumors.

**The Anatomy of the Nervous System. Its Development and Function.** By Stephen Walter Ranson, M.D., Ph.D., and revised by Sam Lillard Clark, M.D., Ph.D. Ed. 10. Pp. 622. Illus. 434. Price, \$9.50. Philadelphia, W. B. Saunders Company, 1959.

Although this text is primarily an anatomical one, it has the same aim as the student using it, which is to examine not only how the nervous system is made up but also as far as possible how it works. In the preparation of this tenth edition, inclusions and alterations have been

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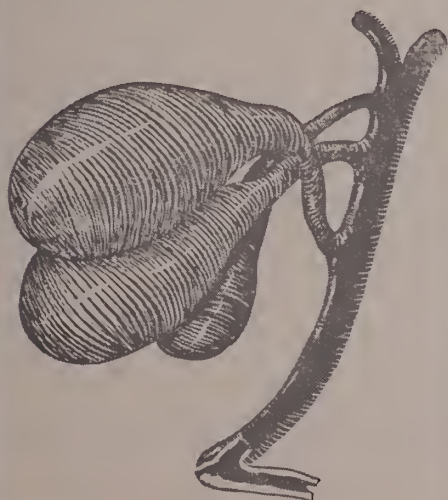
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Source: Skilboe, B.: Am. J. Clin. Path. 30:252, 1958.



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- (1) Beckman, H.: *Drugs: Their Nature, Action and Use*, Philadelphia, W. B. Saunders Company, 1958, p. 425.  
(2) *Biliary Tract Diseases*, M. Times 85:1081, 1957.

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made with the hope that they will aid the student in understanding. Additions and modifications of the text and illustrations have been made in many cases as the results of suggestions from teachers and students who have observed needs as the text was used. This most useful volume is especially well illustrated.

**The Szondi Test: In Diagnosis, Prognosis and Treatment.** By Lipot Szondi, M.D., Ulrich Moser, Ph.D., and Marvin W. Webb, A.M., Ed.D. Pp. 309. Price, \$12.00. Philadelphia, J. B. Lippincott Company, 1959.

In this book are discussed the foundation, rationale, validation, tenets, and diagnostic and clinical applications of the Szondi Test and its theoretic background of schick-sal analysis (from the German Schicksalsanalyse, or fate analysis). This is a projective test based on the patient's reactions to a series of 48 photographs of psychotics and used extensively in Europe for some time although there has been little on it in the literature in English. This book, therefore, fills a definite need for a comprehensive presentation of the values of this particular approach to analysis. Here for the first time the American student of human behavior, whether psychologist or psychiatrist, probation officer or counselor, will find adequate help in mastering the administration and the interpretation of the Szondi Test. It is presented in its true setting of szondian depth psychology, without which the test is meaningless. Included are chapters devoted to psycho-shock therapy, the group application of the test, and forensic psychology.

Described as a rare combination of analytic and scientific scholar and conscientious physician as well as an outstanding psychotherapist, Dr. Szondi, of Zurich, Switzerland, has earned the reputation of being the greatest depth psychologist of his time. Dr. Moser is an analyst and privatdozent at the University of Zurich, and Dr. Webb is Chief Psychologist at the Veterans Administration Center, Bay Pines, Fla.

### An Atlas of Normal Radiographic Anatomy.

By Isadore Meschan, M.A., M.D., with the assistance of R. M. F. Farrer-Meschan, M.B., B.S. (Melbourne, Australia), M.D. Ed. 2. Pp. 759. Illus. 1446 on 412 figs. Price, \$16.00. Philadelphia, W. B. Saunders Company, 1959.

The purpose of this book is to present a practical, useful text for medical students, general practitioners, residents, especially in radiology, and x-ray technicians. In this second edition serial sets of x-rays and tracings cover every common radiographic view, helping the physician decide when he is dealing with a normal examination. There is a normal radiogram of a particular area, plus a tracing of the x-ray with the various anatomic features and aspects clearly labeled, and a drawing or photograph showing the exact position assumed by the patient and the precise location of the cone for obtaining the proper view completes the series. Accompanying these vivid illustrations is concise text description covering the mechanics of securing a successful film, basic anatomy of the area from both gross and microscopic standpoints, changes in growth and development, important variations of the normal, and confusing appearances likely to be met. Among the many improvements in the new edition are replacement of hundreds of illustrations with others of increased clarity, a new chapter on Radiation Protection, a completely rewritten chapter on Bone Growth, more comprehensive bone growth tables, greater emphasis on arteriography and venography of the brain as well as cervical myelography, new and special studies of the heart and great vessels, coverage of the many advances in gastrointestinal radiographic anatomy such as the new concepts of the swallowing function and of the esophagogastric junction, and added material on the improved double contrast colloidal barium and air colon study. The book can be used with profit by any physician who ever has occasion to look at an x-ray film.

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
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**References:** 1. Farah, L.: *Internat. Rec. Med.* 169:379 (June) 1956. 2. Smigel, J. O., et al.: *J. Am. Geriatrics Soc.* 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: *J. Allergy* 29:358 (July) 1958. 4. Eisenberg, B. C.: *J.A.M.A.* 169:14 (Jan. 3) 1959. 5. Maryssael, L.: *Bruxelles-méd.* 32:141 (Jan. 26) 1958. 6. Pfleger, R.: *Med. Klin.* 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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• Desitin Chemical Co.....	777	• G. D. Searle Company.....	731
• Dexter Boyd—Books.....	733	• Smith, Kline & French Labs.....	Back Cover
• Drug Specialties.....	774a	• Surgical Supply Co.....	742
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• Lederle Laboratories.....	682, 683, 691, 694, 737, 738, 739, 746, 747, 749, 754, 755, 757, 759, 763, 770, 776, 778, 780, 781, 784, 786	• Wesson Oil & Snowdrift Sales Co.....	774
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• Lloyd, Dabney & Westerfield, Inc.....	687	• Wine Advisory Board.....	775
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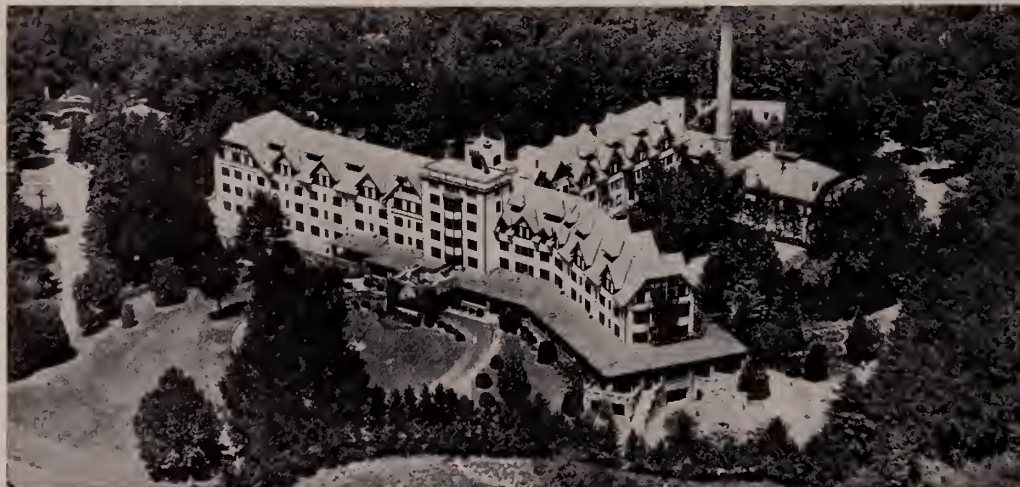
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Academy of General Practice.....	Walter J. Glenn Jr., Ft. Lauderdale	A. MacKenzie Manson, Jacksonville	Jacksonville, April 10, '60
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Urological Society.....	Edwin W. Brown, W. Palm Beach	Wm. A. VanNortwick, Jacksonville	" " " "
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Food Banks, Association.....	Leo L. Foster, Tallahassee.....	Wilma Holt, Pensacola.....	Clearwater, May 13-15, '60
Blue Cross of Florida, Inc.....	Mr. C. DeWitt Miller, Orlando.....	Mr. H. A. Schroder, Jacksonville	Jacksonville, Dec. 2-4, '59
Blue Shield of Florida, Inc.....	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville.....	Jacksonville, April 10, '60
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Diabetes Association.....	J. J. Lowenthal, Jacksonville.....	Morris B. Seltzer, Daytona Bch.....	Miami Beach, Oct., 1960
Dental Society, State.....	A. D. Farver, Miami Beach.....	Richard Chace, Orlando.....	Miami Bch., May 15-18, '60
Heart Association.....	Sidney Davidson, Lake Worth.....	Mrs. E. D. Pearce, Miami.....	Miami, April 30, '60
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Public Health Association.....	A. Y. Covington, Starke.....	N. J. Schneider, Jacksonville.....	
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Woman's Auxiliary.....	Mrs. W. J. Newcomb, Pensacola.....	Mrs. Max Suter, Jacksonville.....	Jacksonville, Apr. 8-11, '60
American Medical Association.....	Louis M. Orr, Orlando.....	F. J. L. Blasingame, Chicago.....	Miami Beach, June 13-17, '60
A.M.A. Clinical Session.....			Dallas, Texas, Dec. 1-4, '59
Southern Medical Association.....	Milford O. Rouse, Dallas, Texas.....	V. O. Foster, Birmingham.....	
Alabama Medical Association.....	William R. Carter, Repton, Ala.....	Douglas L. Cannon, Montgomery	Mobile, Ala., April 21-23, '60
Georgia, Medical Assn. of.....	Luther H. Wolff, Columbus, Ga.....	Chris J. McLoughlin, Atlanta.....	Columbus, Ga., May 1-4, '60
Fla. Chap. Arthritis & Rheumatism Foundation.....			
E. Hospital Conference.....	John P. Mozur, Miami.....	J. Charles McKee Jr., Miami.....	Miami Beach, May 3-7, '60
	Oscar S. Hilliard, Ft. Oglethorpe, Ga.	Glenn Hogan, Atlanta.....	
E. Am. Urological Assn.....	Lawrence Thackston, Or'burg, S.C.	S. L. Campbell, Orlando.....	Jacksonville, March 13-16, '60
Southeastern Allergy Assn.....	C. P. Wofford, Johnson City, Tenn	Kath. B. MacInnis, Columbia, S.C.	
Southeastern Surgical Congress.....	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta.....	N. Orleans, March 21-24, '60



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FREDERICK J. WAAS, M.D., 1928.....	Jacksonville
JULIUS C. DAVIS, M.D., 1930.....	Quincy
WILLIAM M. ROWLETT, M.D., 1933.....	Tampa
HOMER L. PEARSON JR., M.D., 1934.....	Miami
HERBERT L. BRYANS, M.D., 1935.....	Pensacola
ORION O. FEASTER, M.D., 1936.....	Long Beach, Miss.
EDWARD JELKS, M.D., 1937.....	Jacksonville
LEIGH F. ROBINSON, M.D., 1939.....	Fort Lauderdale
WALTER C. JONES, M.D., 1941.....	Miami
EUGENE G. PEEK SR., M.D., 1943, Chm.....	Ocala
SHALER RICHARDSON, M.D., 1946.....	Jacksonville
WILLIAM C. THOMAS SR., M.D., 1947.....	Gainesville
JOSEPH S. STEWART, M.D., 1948.....	Miami
WALTER C. PAYNE SR., M.D., 1949.....	Pensacola
HERBERT E. WHITE, M.D., 1950.....	St. Augustine
DAVID R. MURPHEY JR., M.D., 1951.....	Tampa
ROBERT B. McIVER, M.D., 1952.....	Jacksonville
FREDERICK K. HERPEL, M.D., 1953.....	W. Palm Beach
DUNCAN T. McEWAN, M.D., 1954.....	Orlando
JOHN D. MILTON, M.D., 1955.....	Miami
FRANCIS H. LANGLEY, M.D., 1956.....	St. Petersburg
WILLIAM C. ROBERTS, M.D., 1957.....	Panama City
JERE W. ANNIS, M.D., Secy., 1958.....	Lakeland



# County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	George H. Putnam, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	68
* Bradford, Gilchrist, Union				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	34
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	67
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	253
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	6
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* Baker				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	976
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	26
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	358
* Clay				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	118
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahatchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	241
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	38
* Sumter				
Lee-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	80
Madison	Thomas G. Boulard Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	8
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	37
Marion	Robert E. Thompson, Ocala	William C. Butscher, Ocala	3rd Tues.	34
* Levy				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	8
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	251
* Osceola				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	184
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	20
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	308
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	132
Putnam	Charles E. Barrineau, Palatka	James C. Kitait, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	93
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	6
* Dixie				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	104
* Flagler				
Walton-Okaloosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	34
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

\* Supervise and aid until organized separately.

Direct 3,691

Total 3,698

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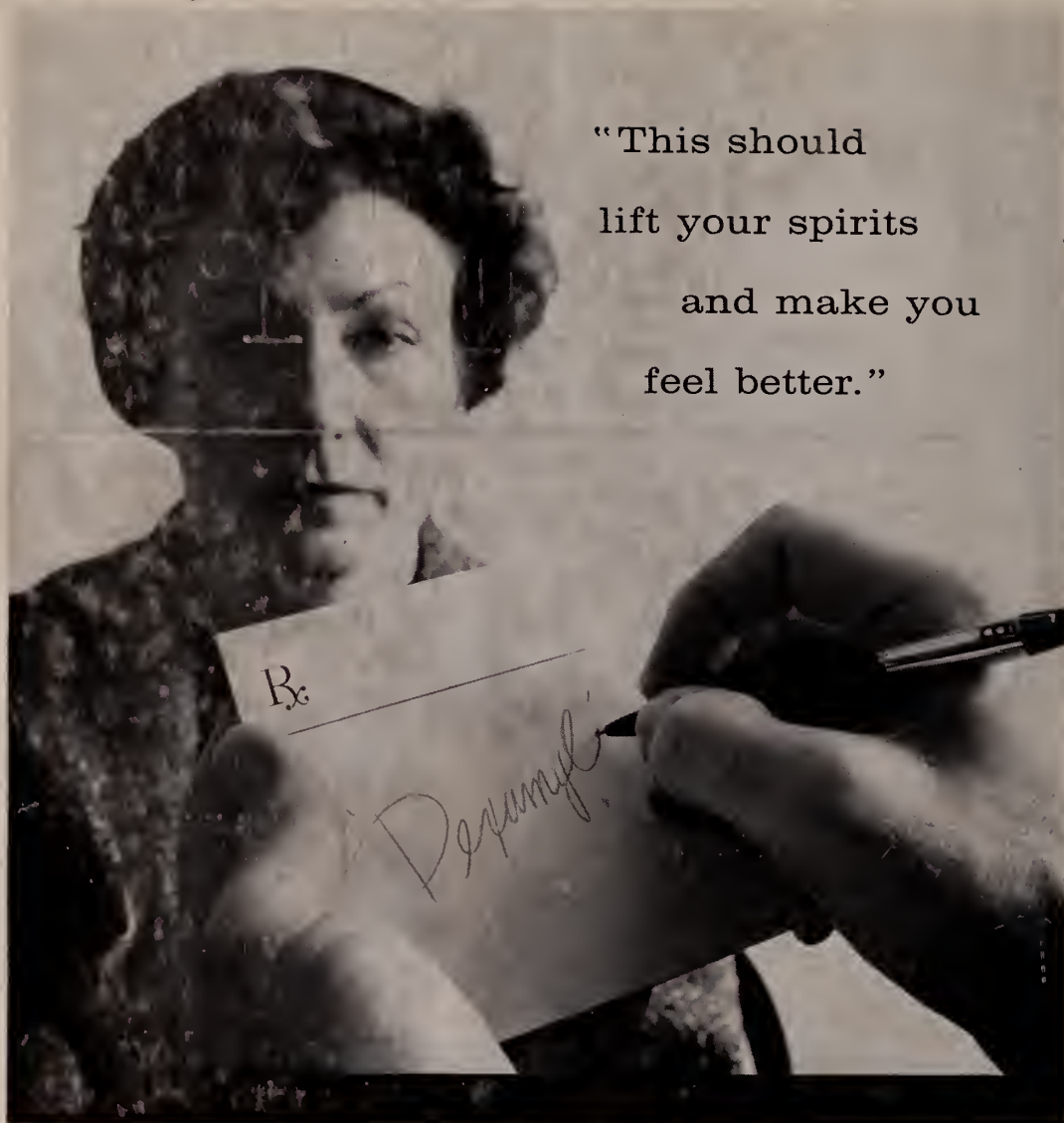
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DUE IN TWO WEEKS UNLESS RENEWED.  
AFTER 6 WEEKS

NOT RENEWABLE AFTER 6 WEEKS

[illegible]





